Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4a per doc g927 5-24-12 vt State of Maryland / Department of Health and Mental Hygiene 20 | 2

		1	For State Registrar	,	Cer	tificate of L	Death		Reg. No.				
	Dhysisis	n/	1. Decedent's Name (First, Middle, La.					2. Date of Dea		Year	3. Time of Death		
	Physicia Medic	al	Ralph	Jackson			Lucation of Docate	May	21°,	2012	4:24 P M		
المياسية	Examin	er	4a. Facility Name of not institution, give Norther Sinai Hospita	Pkwy. Apt 411	L	Baltimo				nty of Death NA			
	Funeral Director		213-34-0105	7. Age (In yrs. le	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day 12-08-	h (, Year) 36	9. Birthp Count	lace (State or Foreign ry) MD		
	show show	ō	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	cation				1	0d. Inside City Limits		
	Maryk 28a-f	Director	MD NA	Ва	1timor				1 ^X Yes 2 □ No				
	with the s 23a or ust be n	Funeral D	10e. Street and Number 1190 W. Northerr	Parkway Apt	·#411	10f. Zip Code 2121	0		10g. Citizen	of What Coun	try?		
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F			Spec	Ameri	can		
15-0	72 hou "natu ledica	Completed	15. Decedent's l (Specify only highest g	rade completed)	(Give i	lent's Usual Occup kind of work done O NOT use retired)	during most of work	ing		of Business Inc ed Stat			
212	within jiene.		Elementary/Seconday (0-12) 12th Grade	College (1-4 or 5+) NA		il Handl				al Serv			
nd	filed via Hyg	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam Amelia	ne (First, Middle,	Maiden Sum Lyons				
<u> </u>	d Men d Men marke matic	-	Ellie A. 19a. Informant's Name/Relationship (10b Mailie	on Address /Street	and Number or Rur	al Route Numbe			21210		
Ma	d 2 sho alth an 27 is er trau		Marlene Y. Jacks		1190	W. North	ern Park	way Apt.	#411 I	Baltimo	ore,MD		
Baltimore, Maryland 21215-0036	Page 1 an nent of He ant: If iterr ary or othe		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	emetery, cren edar Hi	sition (Name of natory or other pla- 11 Cem •	05-4	Date 26-12	Anne A		L Co;MD		
Balt	permit. Departr Imports any inje		21. Signature of Funeral Service Licer	see -	22	2. Name and Address 200 Libe	erty Road	ylie Fur Randall	neral I Lstown	Home P. , Mary	.A. Land 21133		
ľ		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):											
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Type die	lence of:	retion							
تيرسي	Examiner		Commentally list conditions	b. En () Stace Due to (or as a consequence to (or a consequence t	Le Ner	al dis	lese						
	p tt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										
	xecute		Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a consequ									
90	te be e nysicial ne buri	Medical				-							
68760	ertifica ding ph se as th		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d	. Date of deliv	ery		
. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/	in the past 12 months? 1 Yes 2 No 9 Unknown		☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify)					Month	Day Year		
Division of Vital Records, P.O.	uires that t n signed b ild be deta	by	Part II. Other significant conditions	contributing to death but not res left diabeles t	well it	underlying cause g	iven in Part I.	23e. Did t			he cause of death?		
corc	≥ 55 <>	Completed	Pacemorken					24a. Was	DSV	prior to co	psy findings available empletion of cause of		
l Re	n: The ficate l		25. Was case referred to medical	<u> </u>		26 F	Place of Death (Che		ormed? 2 No	1 Yes	2 X No		
Vita	ysicia is certi directo	To Be	examiner? 1 Yes 2 □ No	Hospital:	ER/Outpatie	Ott		lome 5 Resi	dence 6 🗆	Other (Specif	у)		
o u	nding Ph tth. : After th e funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time o injury	Wol	ryat rk? ∐Yes 2 ☐ No	28d. Describe	how injury oc	curred			
Divisio	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page?	Certificate:	3 Suicide 6 Could not 4 Homicide determined	be 28e Place of Injury - At he		reet, factory, office		28f. Location (City or To		umber or Rura	al Route Number,		
_	e Hospit 124 hour e Funera leted fille	Medical	(Chook 2 Modical Evan	ysician: To the best of my know niner: On the basis of examinations arse Practioner: To the best of m	n and/or inves	stigation, in my opin	ion, death occurred	at the time, date	and place, an	a due to the ca	ause(s) and manner stated.		
	To the To the comp	2	29b. Signature and title of certifier		<u>,</u>	29c. Licens	se number		29d. Date s	igned (Month,	Day, Year)		
	,		03.1		n 22c) /T		M3577		1 (0	ey 23,	2010		
6	14		30. Name and address of person who	completed cause of death (liter	EO, (Type	ikesuille	5/119 5	-1133					
	Sta	te	31. Date filed (Month, Day, Year)	32. Bujisti ar's Signa	ature -	to at							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 16502 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Physician/ 05 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Min Months 212-44-1094 **Director** 1 □ M 2 🗓 F 69 11-19-1942 MD Usual Residence of Deceden items 23a or 28a-f show her must be notified at 10a. State 10b. County death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD. n/a 1X Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1608 St. Stephens Street 21216 IISA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: SpecifyAfrican-American Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene.
27 is marked other than "r r traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) General Services Admin. University of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. မ Charles Goines Elizabeth Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Lee/Son 5229 Farm Pond Lane, Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 5-29-2012 Woodlawn, MD 21. Sign 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 9200 Liberty Rd., Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy þ Pregnant at time of death Day the 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No After this certificate has page 1 ☐ Yes 2 ☐ No the funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မှ 1 🔲 Yes 1 Kg Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending s after death. 1 Yes 2 No M Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) npletely filled in by 28f. Location (Street and Number or Rural Route Number determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of eertifie no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimorr. GREENE ST 31. Date filed (Month, Day, Yea State

Registrar

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2012 16	5	0	-
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		1- For State Registrar			Certific	cate of	Death			R	Reg. No.			
Physician 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year												3. Time of Death		
Medical Examiner Janna Marie Johnson Month May 21, 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death													1337 hrs	
		 Facility Name (if not instituted) Philadelphia Court 							of Death		4c. County of Baltimor		nty	
Funeral	╗	5. Social Security Number	6. Sex	7. Age (In yrs. last bi	rthday)	If Under 1 Ye	_	er 24Hrs.	8. Date of Bi	irth (MM/DD/YYYY			
Director		216–11–7713	1 M 2 XXF		26	Yrs.	Months Da	ys Hours	Min.	Novemb	er 10 , 1985	Foreign Cour	ntry) Marryland	
yna	H	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										10d. Inside City Limits		
. .	ō		imore		Notti	ngham						1 ☐ Yes 2 XXNo		
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Director	10e. Street and Number 2 Viewridge I	Orive Apt.	. E			10f. Zip Code 21236				10g. Citizen of Wr United			
th with tems 23.	Funeral	11. Marital Status 1 X Never Married 2		ecedent Ev Forces?	er in U.S.		Decedent of h				o- 14. Race White		an Indian, Black,	
fter dear ", or it			1 Yes		X No		res 2 X N				Specify:	Whi	te	
ours at	ē P	15. Decedent's Education (Sp	or Dates:		eted) 16a.		Usual Occup				16b. Kind of Bu	siness/In	dustry	
24	Completed	Elementary/Secondary (0-12	2) College	(1-4 or 5+))		st of working li	ie. DO NOT	use retire	u)				
21215-0036 Uld be filed within 72 Mental Hygiene, marked other than " event, the Medical	Ĕ.	10				Cash	ıer	14044	t- M (1		Food S		ce	
		17. Father's Name (First, Middl Gordon Johnson							-		Maiden Surname)		
2121 wild be fi Mental I marked	To Be	19a. Informant's Name/Relation			119	9b. Mailing /	Address (Str			rie Tu	mber, City or Tow	n State 2	Zin Code)	
MD d 2 should hand 3 is a 27 is a martic	-	Sharon Close		ner)			•				lle, Mar			
e, M l and 2 Health item 2	ŀ	20a. Method of Disposition					on (Name of c	emetery,		Date	20c. Location -	City or T	own, State	
Baltimore, MD 2 semit. Pages 1 and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic		1 XxBurial 2 Crematic	_	from State		atory or other	n Cemeter	y	May	25 , 2012	Camp Hi	11, R	emsylvania	
Baltimo permit. Page: Department o Important: injury or oth	ł	21. Signature of Funeral Service	specify: ce Licensee			22. Na	me and Addre	ss of Facility					1 173	
E E E	ŀ	Shifelly	Collis			1 8	28M Har	form Ro	en∏ Par	حالتيك	ion Servic Marvl <i>a</i> nd	21234	rkville	
Physician		23a. Part I. Enler the disease of failure. Listoply one cause	or complications that se on each line.	caused the	e death. Do r	not enter the	mode of dyin	g, such as c	ardiac or r	espiratory arr	rest, shock, or hea	art	Approximate Interval Between Onset and	
/Medical Examiner		Immediate Cause (Final diseas	se a. Narco	tic a	nd Coc								Death	
. 1	-	or condition resulting in death)	Due to (or as	a consequ	uence of):									
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xecuted n and - transit		events resulting in death) Last	d.	_ `	,									
ਹ ਕੋਵੋਂ	/Medical	▼ UNPENDED	AMENDE	23a,2	27,28a	-f,pe	r me,g	928 6-	19–12	2 sm				
	₹[IF FEMALE: 23b. Was decedent pregnant in			of pregnancy		Ideath 3	Ectopic	pregnanc	:v	23d. Date of Month	delivery Da	y Year	
Records, P.O. Box 68: The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician	past 12 months?	4 Pre	gnant at tim	an of dooble	-=	er (Specify)							
Be he dea	چّا.		9 Uni	nown		l- 4b	d= d. d= = =	niven in De	.4.1	Tage Did to	ahasaa uga santri	huta ta th	e cause of death?	
P.C	2	Part II. Other significant cond	illuons contributing	to death b	ut not resultir	ng in the un-	derlying cause	given in Pa	ITC I.	_	_	_	bly 4 V Unknown	
ords, w requires s been sig	Completed									24a. Was			psy findings available	
Division of Vital Records, ral or Attending Physician: The law requiring after death. The death. Director: After this certificate has been sited in by the funeral director, page 2 should be.	톍									autop perfo		rior to cor eath?	mpletion of cause of	
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visi or Att her de birecte in by t	<u></u>		estigation 1d 28e. Pl	ace of Injur			factory, office	building, et	c. 2	Bf. Location (Street and Number	er or Rura	Route Number, City	
Divis Hospital or A 24 hours after Funeral Directely filled in by	Certification:		ermined (Specif	y) Fo	und:In	Hote	1 Room		4				nn Room 524 osedale,MD	
9-37	Medical	tonical dray	Physician: To the b	-	-									
To To	ĕ	29b. Signature and title of certif	and manner	stated.			29c. Licer	se number			29d. Date signe	ed (Monti	n, Day, Year)	
	1	(Salah	\mathcal{L}				0.0	.M.E.			May 22, 20	12		
	1	30. Name and address of person	on who completed ca	use of dea	th (Item 23a)									
\varnothing		Laron Locke MD.	Assistant Medic	al Exam	iner 900	W. Balt	imore Stre	et, Baltim	ore, MI	21223				
Sta Registr		31. Date filed (Month, Day, Tear	32.	Regiotrar's	Signature	1								
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State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	State of Mi	-	Certificat				Reg. No.	012	1650	4
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Med Exam	dical iner			ر پر	4b. City,	Town, or Location	ion of Death		4c. Cour	nty of Death	0000	\exists
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Funera Directo	_	218–28–0112	i. Sex 7. Age 1 ☐ M 2 🔀 F	e (In yrs. last birth	Months	Days Hour	der 24 Hrs. rs Min.	8. Date of Birtl (Month, Day		9. Birthp Count	lace (State or Foreign ry)	1
		Usual Residence of Decedent		103				Nov 6,	1908		ansas	_
ryland -f sho	to to	10a. State 10b. County		10c. City, Town						1	0d. Inside City Limits	
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death items	Funeral		12. Was Decedent E Armed Forces?	Ever in U.S.	13. Was Deced	dent of Hispanic oify Cuban, Mexi		ecify Yes or No-	14. R	ace - Americ	an Indian,	\exists
be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	À		1 Yes 2 X If Yes, Give	No	i .	2 No Spec		Thours, c.c.,	Speci	lack, White, e		
hours	Completed	15. Decedent		16a.	Decedent's Usu	al Occupation			16b. Kind of	Business/Inc		
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should and Me is mark		19a. Informant's Name/Relationship		19b.	Mailing Address		-			-		_
4.43.2		Harriett Jacobs	Robson/Dau	ghter 22	2647 Riv	er Ridg	e Rd.	Bozman,	MD 21	612		
Page 1 arment of H ant: If ited ury or oth		20a. Method of Disposition 1 □ Burial 2 X Cremation 3	B ☐ Removal from State	cemeter	Disposition (Nar y, crematory or c	ther place)	1	Date	20c. Location	•		
→ → → → →		4 Donation 5 Other (Sp 21. Signature of Funeral Service Lice		Final Jo			_					
Depart any i	0	Deval f	Helle							. Box sville	784 e, MD 2102	9
	8	23a. Part 1. Enter the disease, or c shock, or heart failure. List on	omplications that caused by one cause on each line	the death. Do no	ot enter the mod	e of dying, such	as cardiac o	or respiratory arm	est,		Approximate Interval Between	ď
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ith cer ttendi for use	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death						Date of delive	ry Day Year	
Attending Physician: The law requires that the death certificate be executed ar death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/	1 Yes 2 No 9 Unknown	4 Pregnant a	t time of death	5 ☐ Other (s _t	pecity)						
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requires been sig								1 🗆 1	′es 2. 🕱 No	3 Prob	ably 4 🗆 Unknowr	n
law re has be	Completed	.						24a. Was a autop	sv	prior to cor death?	sy findings available npletion of cause of	
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ding Ph h. After thi funeral			28a. Date of injuit (Month, Day	ry 28b. Ti		8c. Injury at work?		28d. Describe h				
ttendi death. stor: A / the fi	Certificate:	2 Accident Investiga 3 Suicide 6 Could no	ot he	A1 h ==== 6==	M	1 🗌 Yes 2						
pital or Attencours after death eral Director.			ed 28e. Place of Injubulding, etc		m, street, factor	/, office		28f. Location (S City or Tow		ber or Rural	Route Number,	
To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f	Medical	29a. Certifier 1 Certifying F (Check 2 Medical Ex only one) 3 Certifying N	Physician: To the best of aminer: On the basis of extended the properties of the pro	xamination and/or	investigation, in	my opinion, deat	th occurred at	the time, date ar	nd place, and o	due to the cau	ise(s) and manner stat	ed.
To the with To the com		29b. Signature and the of certifier	1)			. License numbe	er		29d. Date sign	ned (Month, E	Day, Year)	
			Mhi mu ni			0057	908		5/	22/13		
		30. Name and address of person wi	PATTENSON		ype, Print) 2005, TA	LAUT S	5 5	F. MIC	HAELS	s Mits		
St Regist	tate trar	31. Date filed (Month, Day, Year) MAY 2 4 2012		ar's Signature								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 16505 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2012 2. Date of Death 3. Time of Death Physician/ Month Day 17 6:09 A M Naji Nabil Khalil May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Gilchrist Hospice Center Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD Funeral 7. Age (In vrs. last birthday) (Month, Day, Year) 10-07-55 Days Hours Min. 212-60-9109 Director 56 1 X M 2 □ F Usual Residence of Deced is then "neturel", or items 23e or 28e-f show the Madical Examiner must be notified at 10a. State 10c. City, Town or Location filed within 72 hours efter death with the Maryland 10d. Inside City Limits Director XX Yes 2 No MD NA Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24 Rose Petal Court 21234 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc.African Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: American 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 end 2 should be filed within 72 ment of Health end Mental Hyglene. ent: If Item 27 is merked other then ' ury or other treumetic event, the Ma Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade Relator Self-emploved 3vrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Richards Omega Richards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5808 Glenkirk Court Baltimore, Maryland 21239 Ingrid L. Richards-Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of H Importent: If its eny injury or ot 1 Burial 2 Cremation 3 Removal from State King Mem. Pk. Cem. 05-21-12 Randallstown, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Streét Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death storenal syndrome Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sitrena 5 M Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospitel or Attending Physicien: The lew requires that the deeth certificate be executed within 24 hours effer death.

To the Funerei Director: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use es the burial-trensit Exam Dr coho ano Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? ☐ Ectopic pregnancy 5 Other (specify) Day Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 KLNO Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) Hospital: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my antique. Medical 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WW) 6701 0 11 State Registrar's Signatur Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND 28A, PER ME C931 9/14/12 TRT TRT Amend Item 288 aper me, g927, 05/23/2012 dhb 16506 State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Audrey Ma^{₩nt}12, 2012 Physician/ Α. Kunz 2:55 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist <u>Towson</u> If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 - M 2 X F Days Min 10/23/1924 87 Maryland Director 212-20-2810 Usual Residence of Decedent 28a-f show of Health and Mental Hygiene. item 23a or 28a-f shor item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Towson Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 Page 1 and 2 should be filed within 72 hours after death with 1055 W. Joppa Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Horse Academy 0wner 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hattie Sands Charles Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl Baxley, Jr. / Nephew 7101 Brigantine Blvd Oriental, NC 28571 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other o 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corp. 5/16/2012 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 11 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit La that initiated events **Hospital or Attending Physician:** The law requires that the death certificate be ex**e**ct 24 hours after death. Due to (or as a consequence of): resulting in death) Last Physician/Medical #280 Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Yes 2 No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause wen in Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🗌 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, 2012 28d. Describe how injury occurred Patient had set tout 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ► No **Unknown**M 2 Accident Investigation 09/1912 Chair and Fell on the Floor 2 f. Location (Street and Number or Rural Route Number 3 Suicide 4 Homicide 6 Could not be Pla e of Ir ury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State)
1055 N DAPA Rd, TOWSON MD 21204 Blah shorest Parsacut Comment, Award hub 1055 N DAMA Rd, Tows Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one e of certifie 29b. Signature and ti 29c. License number 29d. Date signed (Month. Day, Year) 71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD KUHAR 6701 10 CHARL 31. Date filed (Month, Day, Year)

MAY 2 3 201 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 16507 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month BION Wi KNIGHT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 542 Russell Avenue Gaithersburg Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 □ F Months Days June 1 , 1924 265-20-4468 Frorida Yrs **Director** 87 Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code o 10g. Citizen of What Country? 23a Funeral 542 Russell Avenue 20877 United States Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter rmed Forces? Black, White, etc. þ 1 Never Married 2 Married 2 No Maryland 21215-0036 If Yes, Give Year or Dates. 1945–1973 1 ☐ Yes 2 🖾 No Specify: Specify: White Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired College (1-4 or 5+) **5+** Elementary/Seconday (0-12) U.S. Army General Officer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 Marion Russell Albion W. Knight, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. 542 Russell Ave., Gaithersburg, Maryland Nancy Knight/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Montgenier atory or other place) 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State May 25, 2012 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Crematoriúm, Inc. 21. Signature Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave. Rockville, Maryland 20850 M00198 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ CONGESTIVE HEART ERE disease or condition Medical resulting in death) **Examiner** Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). Cause (Disease or iinjury that initiated events resulting in death) Last and -trar Due to (or as a consequence of) burial attending physician for use as the buria Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death been signed by the a should be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2XNo 3 Probably 4 Unknown 1 🔲 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy perform certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certific 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) examiner? Other: 2 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) ole 20x 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

MD 20850

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Shady Grove RD #100, Rockville,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 16508 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D2012 Month May Koscielski THeresa 22 9:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death **Examiner** Sparrows Point 7404 Bayfront Road Social Security Number 8. Date of Birth (Month, Day, May 31, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months 216-20-9598 1 M 2 X F Days Hours Maryland **Director** 85 May 1926 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location at 10d, Inside City Limits Director notified Sparrows Point 28a-f Maryland Baltimore 1 Yes 2 X No the 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? ms 23a or must be r Funeral 21219 USA 7404 Bayfront Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: White 'natural", 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 8 years Housewife Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Stanley Knozek Katherine Jaworska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7404 Bayfront Road, Sparrows Point, Maryland 21219 Alice Koscielski Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H
Important: If ite
any injury or oth May 26, cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 2012 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore, Maryland Ignature of Frineral Service Licensee Connectly Funfarial Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 omplications that caused the death. D 23a, Part 1. Enter the disease not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. Lift only one cause on each line. Immediate Cause (Final Onset and Death UNGESTIVE LIEART FAILURE Physician/ disease or condition resulting in death) leavs Medical Due to (or as a consequence of) Examiner HRONIC LUNG DISCIAS Years Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) FIBRILLATI been signed by the attending physician and should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Other (specify) 9 Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Hypertension has page 2 autopsy Clostridium Officile After this certificate Yes 2 Z Division of Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. 2 Accident or Attend after death Director: Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide determined spital within 24 hours completed filled Medical 1 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1 gr D59805

State

Registrar

DHMH 17 Rev 7/2009

blud # 200. BALTIMORE, MARYLAND 21236

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4924 Compbell

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 16509 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ Kentz 2012 9:50 Marv Joan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Timonium Stella Maris Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Hours Min. Director 217-54-9870 1 M 2 K F 93 Nov 3, 1918 New Jersey Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2X No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 6806 Bellona Ave. USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2x ☐ No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. Do NOT use retired)
Educator/ Pastoral Associate 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Education/ Church 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Dunne Kentz John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Religious 305 Cable St. Baltimore, MD. 21210 Agnes Rose McNallv Order 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation / 5 ☐ Other (Specify) 5-24-12 Ellicott City, MD. lchester Cemetery Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 21. Signature of # ineral Bervice Vicens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RENAL DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sician and burlal-transit • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and ately filed in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown MARY KENTZ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

1 Yes 2 No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🕱 No Other: 4 Nursing Home 5 Residence 6 K Other (Specify) HOSPICE မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury_at 28d. Describe how injury occurred Natural
Accider
Suicide 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Hospi within 24 hou To the Funer completely fil 29a. Certifier (Check 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

9:50

2012

31. Date filed (Month, Day, Year) MAY 2 4 201

CRNP

JACKIE JONES,

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 1 2

			For State Registrar		, y	Cert	tificate of L	Death		Reg. No	2012	! (0010
			1. Decedent's Name (First, Middle, Las	st)					2. Date of De Month	ath Da	y Year		of Death
	Physici /Medio		Marion J. Kolbe						May	22	2012	122	00 M
	Examir	er	4a. Facility Name (If not institution, giv		0.1			Location of Death	SE O	40.	. County of Death		
	Francis		5. Social Security Number 6. S		(In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	th Voor	9. Birth	place (State	e or Foreign
	Funeral Director			□маДГ	82	Yrs.	Months Days	Hours Min.	April 2	2,193	30 Maryl		
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	ation					10d. Inside	City Limits
	aryla:	'n					ation					1 □Y€	s 2XNo
	the M	Director	Maryland Baltimon	e	Arbuti	us	10f. Zip Code			10g. Ci	itizen of What Cou	ntry?	
	death with the Maryland ims 23a or 28a-f show	Ö	5555 Link Ave.				21227			Uni	ted State	ès.	
	death	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. W	/as Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Ameri Black, White,		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be redified at once.		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ∏Yes 2 XX If Yes, Give Year or Dates:	Ď		∐Yes 2⊠No	Specify:			Specify: Whi		
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Z	shoul nd M mark umati	ျှ	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Street	and Number or Run	al Route Numb	per, City	or Town, State, Zi	p Code)	
2	alth a		Joseph W. Kolbe,	Gr./ Husban				., Arbutu		and	21227		
ore.	es 1 a of He filtem		20a. Method of Disposition	Removal from State			sition (Name of natory or other place		Date		_ocation - City or T		
im	Page tment tant; I		4 □ Donation 5 □ Other (Speci		Loude			ery May 2					and
Baltimore. Maryland	permit Depart Import amy in		21. Signature of Funeral Service Lice	nsee RAL	1			ess of FacilityAMB hur Sprin			-		21227
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	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	1 eur		ua.						
b	Examiner		O	h									
	/ D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequer	nce of):							
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N N	death	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at			Other (specify)				Month	Day	rear
) d	at the	Phy	9 ☐ Unknown Part II. Other significant conditions		et not roculti	na in the ur	aderlying cause di	ven in Part I	23e. Did	l tobacco	use contribute to	the cause	of death?
4	Attending Physician: The law requires that the death certificate be executed redeath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions	contributing to death bu	it not resulti	ng in the th	luchying oddoo gr						Unknown
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O L Ber	The law cate has page 2 s	ם							aut	opsy formed?	death?	completion 2 🗆 No	of cause of
7 1	ician: The certificate ector, pag	ပိ	25. Was case referred to medical		·			26. Place of Dea	1 □ Yes th (Check only		VO TILITES	2 🗀 110	
	ysicia is cer direct	o Be	examiner? 1 Yes 2 100	Hospital:	ent 2 🗆 EF	R/Outpatier	nt 3 DOA Ot	her: 4 Nursing H	ome 5 ☐ Re	sidence	6 ☐ Other (Spe	cify)	
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	tendii eath. or: A the fu	catic	2 Accident investigation]Yes 2□No	206 Location	(Chung)	and Number or Ru	ural Poute	Number
Division of	or At after d Direct in by	Certification: To	4 Homicide determined	28e. Place of Inju- building, etc	ury - At nom- c. (Specify)	e, tarm, str	eet, factory, office		City or T	own, Sta	are)	nai riodic i	varibor,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: /	ical Ce	(Check only 2 Medical Exa	Physician: To the best aminer: On the basis o	f examinatio	edge, deat on and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occu	e, and due to the irred at the time	ne cause e, date a	e(s) and manner a and place, and due	s stated.	se(s)
	thin 2, the F	Medical	one) 29b. Signature and title of certifier	and manner sta	ated.		29c. Licer	se number			Date signed (Mont		
	or With		> Meeh Ag	ar	ME) .		2638	8		5/22/	12	-
	4			19 RAWAL				V AVE,	BAC	TIM	IORE -	212	29
	St Regist	ate trar	31. Date filed (Month, Day, Year)	12 Lewis	ar's Signatu	ba	Ked						

DHMH 17 Rev 1/2001

16511 State of Maryland / Department of Health and Mental Hygiene 2 0 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AM Medical 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Spita If Unde (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** -780 Hours Country Director 1 M M 2 □ F 1941 permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f ahow eny injury or other traumetic event, the Medical Examirer must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 0 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ava Cousin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Goldsboro, NC Denation 5 Other (Specify) 21. 5 of Funeral Service Licenses March FIH-East 1101 E. North Ave. Pa i 1. Enter the disease, or complications that caused s ock, or heart failure. List only one cause on each like the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death I Liate Cause (Final lise se or condition Physician/ Medical ulting in death) Due to (or as a consequence of Examiner DOUN GAY Sequentially list conditions, any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) anding physician end use as the buriai-transit Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death cartificete ba execu Due to (or as a consequence of): Physician/Medical Box 68760 the ettending property that the design of th IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month signed by the et d ba deteched fo Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pega 2 s has autopsy Aftar this certificata 2 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ၉ Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this ately filled in by the funeral 27. Manner of Dea 1 Natural 2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Tplateiy . Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 800 31. Date filed (Month, Day, Year) State Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

16512

		4	For State Of IVIS	aryland / Depa Car	tificate of D								
			Registrar 1. Decedent's Name (First, Middle, Last)		till cate of D	Catri	2. Date of Dea	Reg. No.	2012 3. Time of Death				
	Physicia Medic	n/	Helen A Lake				Month O.5	5 Day 22	Year / / 000 M				
	Examin		a. Facility Name (if not institution, give street and number)	inesic	4b. City, Town, or		e Animic I						
			Severna tark Sc. Social Security Number 6. Sex 7. Age	8. Date of Birt	h	Birthplace (State or Foreign							
	Funeral Director		166-20-1629 1 □ M 2 🖫 F	85 Yrs.	Months Days	Hours Min.	July 0	2 1926	PA PA				
	d wor	. r	Usual Residence of Decedent 10a, State 10b, County	10d. Inside City Limits									
	arylan a-fsh ifieda	ecto	Maryland Anne Arundel	10c. City, Town or Lo		sadena			1 ☐ Yes 2🌠 No				
	the M	-= 1	10e. Street and Number		10f. Zip Code			10g. Citizen of W	hat Country?				
	n with	nera	3500 Lochearn Court Apt. H			122	ooify Vos or No-		SA - American Indian,				
	r death	by Fu	11. Marital Status 1 Never Married 2 Married 12. Was Decedent E Armed Forces? 1 Yes 27	iver in U.S.	Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)		, White, etc.				
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Maryland	Ild be la Menta	의	Benjamin Mrozek			Mary		nowski_	. 7. 0.43				
Mar	2 shouth and the strain of the		19a. Informant's Name/Relationship (Type, Print) Deborah J. Sosnowsky (Dauc	1	ng Address (Street a				, MD 21798				
ē,	I and it Healt item 2		20a. Method of Disposition	20b. Place of Dispo	osition (Name of		Date 24		City or Town, State				
E O	Page 1 nent of int: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metro Cre	matory or other place matory Ir	1 4 -	12	Baltimo	re, Maryland				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	2	2. Name and Addres	ss of Facility Intain Ro	Stalli ad, Pas	ngs Fune adena, M	ral Home, P.A. D 21122				
\$-1d-			23a. Part 1 Enter the disease, or complications that caused	the death. Do not ent					Approximate Interval Between				
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	Medical Examiner		111 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	a consequence of):					unknown				
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Box 68	The law requires that the death certific sate has been signed by the attending page 2 should be detached for use as	Physician/M	in the past 12 months? 1 Ves 2 No		☐ Ectopic pregnand ☐ Other (specify) _	,у		Moi	nth Day Year				
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Division of Vital Records,	r Atte fter de irecto n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of In building, et	jury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location City or To	(Street and Numbe wn, State)	er or Rural Route Number,				
۵	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best o	f my knowledge, death	n occured at the time	e, date and place,	and due to the c	ause(s) and mann	er as stated.				
	the Hos hin 24 h the Fun mpleted	Medical	(Check 2 Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To the	evamination and/or inve	estigation, in my opini , death occurred at the	on, death occurred ne time, date and pl	at the time, date	he cause(s) and ma	anner as stated.				
	Vithi Vithi Con		29b. Signature and title of certifier	CONO	29c. Licens	78-08		29d. Date signed	d (Month, Day, Year)				
)		30. Name and address of person who completed cause of	death (Item 23a) (Time	Print)	10 10							
P			30 Name and address of person who completed cause of	RNPU	1934 F	Friatio	n 61	vd Su	1te B M021061				
46	Sta		31. Date filed (Month, Day, Year) 32. Regist	rar's Signature	A. J. J. J.	E	olen B	urnic,	MID 21061				
	Regist	rar	MAY 2 4 2012 /	. / A	Rikes								

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 2012 State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death May 22, ^{Day} 2012 Physician/ 8:45A M Robert Coleman Lind, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Ivv Hall Geriatric Center Middle River 8. Date of Birth (Month, Day, Year) 04/29/1939 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours 218-36-2174 1 X M 2 🗆 F Director 73 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Baltimore Middle River 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7 Cypress Lane 21220 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 01 1 Yes 2 X No If Yes, Give Year or Dates. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Completed 3 Widowed 4 □ Divorced White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Baker Bakery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, bef Charles Edwin Lind, Sr. Ruth Evelyn Duvall t. Page 1 and 2 should by thent of Health and Mer rant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 757 Seawall Road, Baltimore, Maryland 21221 Robert Coleman Lind, Jr. (Son) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 05/23/2012 Baltimore, Maryland 21 Signature of Euneral Service Licensee 22. Name and Address of Firski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ men Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Live Birth 2 Linear Service
Pregnant at time of death
Unknown Month Day Year 1 L Yes 2 L Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? Yes 25. Was case referred to medical the Hospital or Attending Physician: 26. Place of Death (Check only one) Other: 2. 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗌 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only or (Month, Day, Year) 29d. Date signed State Registrar

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DHMH 17 Rev 06-2011

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 for State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas Francis Lyons, Jr. Month 05 20 2012 10:15 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4912 Morello Rd. Baltimore Social Security Number Sex 11 M 2 D F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 217-58-9415 Days (Month, 29/1932) 60 Yrs Maryland **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4912 Morello Rd. 21214 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify. Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Service Writer Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas F. Lyons, Sr. Helen Oligney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Lynn Lyons / Daughter 3527 Horton Ave, Baltimore, MD 21225 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Chesapeake Crematory 4 Donation 5 Other (Specify) 5/21/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) MONTHS Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury Hospital or Attending Physician; The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death the g Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has b autopsy performed Yes 2 After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director examiner? Other: 4 \(\sum_{\text{Nursing Home}}\) ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Accident after death Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar (Check

only one)

29b. Signature and title of certifie

within 2 To the I

the

who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year,

29c. License number

				Pleas	e type or Pri						-		_	e.		
				For State	State of Ma	aryland / I				and M	ental Hy	giene		1.0		
				Registrar			Certifica	te of L	Death			Reg. No	20	12		151
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	th the	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, <u>the Medical Examiner must be notified at</u> once.	Funeral Director	10e. Street and Number	1.10		10f. Z	ip Code	/ A 1	0		10g. Ci	itizen of What		y?	
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	-			23a. Part 1. Enter the disease, or conshock, or heart failure. List only	mplications that caused one cause on each line	the death. Do r	not enter the mo	de of dying	g, such as	cardiac or	respiratory ar	rrest,		1 1	Approximate nterval Betwo	reen
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Ξ	σ. ξ	has been signed by the attending phys ge 2 should be detached for use as the	by	Part II. Other significant conditions	contributing to death be	ut not resulting	in the underlying	cause giv	en in Part	I.	23e. Did t	obacco	use contribut	e to the	cause of de	ath?
K	Records,	een si	Completed					-			10	Yes 2	□ No 3 □] Proba	bly 🏋	Inknown
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	on C	r: Afte	icat	1 Natural 5 ☐ Pending 2 ☐ Accident Investigati	on (Month, Day	Year) i	njury M	work	? Yes 2 □		od. Describe i	now argui	y occurred			
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	Divital ours aff	ral Di lled ir)	110					: 1	City or Tov					
	Hospital	To the Funeral Director. After this certificate ha completely filled in by the funeral director, page	Medical	(Check 2 Medical Example (Check 2 Medical Exam	nysician: To the best of a miner: On the basis of ex	amination and/c	or investigation, in	my opinio	n, death oc	ocurred at t	he time, date a	and place	e, and due to t	he caus	e(s) and man	ner stated.
	To the	o the	Σ	only one) 3 X Certifying Nu 29b. Signature and title of certifier	irse Practitioner: To the	best of my kno		curred at the c. License		te and plac	e, and due to		e(s) and mannet te signed (Mo			
4	_ ^			> Ma	eni)NID A	P	01	20-	10:	2	5	112/	20	10)
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				TRACIE L. MORGAN			NEY VAL	LEY R	D. 7	TIMON	IUM, M	D 21	093			
		Stat Registra	-	31. Date filed (Month, Day, Year) NAY 2 4 20	12 Personal 12	r's Signature	parke									
		J	-	MINI M T DA		-										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND PITEM#29d, perPHYS, 6928, 674776 All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 for State Registrar 16516 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mav Alexander Ludlam Michaux Jr. 2012 9:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Brightview Mays Chapel Ridge Timonium Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 217-18-7473 **Director** 1 X M 2 🗆 F 90 Feb. 28,1922 Virginia Usual Residence of Decedent 28a-f show 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Lutherville Timonium 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 12261 Roundwood Road, Unit 202 21093 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No 1942If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced White Completed 1969 Year or Dates Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other th Officer Marine Corps Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alexander Ludlam Michaux, Sr. Agnes Fink other traumatic 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Michaux Gonzales 1 and 2 s f Health item 27 2221 Foxbane Sq., Baltimore, Maryland 21209 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of IImportant: If ite
any injury or ot 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 05/21/12 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final MYOCARDIAL INFARCTION Onset and Death disease or condition MINUTES Medical resulting in death) **Examiner** ARTERIOSCLENOTIC CARDOUASCULAR DISERSE YEMRS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) use as the burial-tra Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year 1 Yes 2 No should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DOLYMYBUGIA MHEUMATICA, PERIPHERAL Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown RECURRENS PSPIRATIONS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy UTU SWALLOWING DIFFICULTIES Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted Living Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 2 🖵 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death Funeral Director: A the Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. May 21 Mont 201 2 ear) 126394 marki)

X DHMH 17 Rev 06-2011

State

Registrar

WEGLEIN 6535 W.CHARLET

BALTU

MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 2 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Pranode Milak Physician/ Month 05 Year Lata 0850 AM 22 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1606 Kings View Prive Harford BelAir 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2X F Days India Punjab, 67 Months Feb. 02, 1945 212-82-0637 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1606 Kings View Drive 21015 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Indian If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Coilege (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kiran Maliwal Kundan Lal Chandak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1606 Kings View Drive, Bel Air, Maryland 21015 Dr. Surendra K. Milak Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Evans Funeral Chapel
Bel Air ☐ Burial 2 🏿 Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 Donation 5 Other (Specify) e di uneral Service Licensee Jeffsrey R. Testermen 21. Signat 22. Name and Address of Eacility Evans Funeral Chapel & Cremation Services — Bel Air (M01543) 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Metastatic Ampullary Carcinama Physician months disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Dire to (or sella nonsequenne of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlar-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Lymphocytic tlypophysihs 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? tlypothyro.dism 24a. Was an autopsy performe 1 🗆 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home Residence 6 Other (Specify) 2 Z No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🔎 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month: Day, Year) 29c. License number 05/22/2012 eislan Thile MD 2000 48050 Huspitality Way # 102 Aberdeen, MD 21001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 998 Prashant Shukla, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAY 2 4 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May William Myers ^D2012 Robert 23, 8:50 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 322 Townsend Road Essex Baltimore Social Security Number **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) Days Hours 218-72-9098 Director 53 09/26/1958 Maryland Usual Residence of Decedent 28a-f shov 10a, State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 Yes 2X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or items 23a Funeral 322 Townsend Road 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married þ within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced 4 Divorced White Completed Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working of Health and Mental Hygiene.
item 27 is marked other than
other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked ony injury or other traumatic eve George Marvin Myers, Sr. Elaine Marie Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine Helen Myers (Wife) 322 Townsend Road, Baltimore, Maryland 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1

Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Holly Hill Mem. Gard. 05/26/2012 Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A Signature of Funeral Service Licensee Old Eastern Avenue, Essex, Maryland per the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rheart failure. List only one calls on each line. Interval Beam Onset and Debin Metastas Immediate Cause (Final Phonocount MOW Medical ng in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No detached for Month Day Year Pregnant at time of death Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by page 2 should be Division of Vital Records, or Attending Physician: The law requires Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Yes 2 certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident Sulcide the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certif 29d. Date signed (Month. Dav. Year. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOLABIKA ALE BALK MD 21222 730 31. Date filed (Month. Dav. State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2 Date of Death . Decedent's Name (First, Middle, Last 3. Time of Death Physician/ 10:26 A rginia ma 2012 Medical itation, give stree 4c. County of Death 4b; Oity, Town, or Location of Death **Examiner** Age (In yrs. last birthday) g. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth **Funeral** Min. Director 1 □ M 2 👿 items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No timore 10e Street and Nue 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2. Was Decedent Eve Medical Examiner Black, White, etc. 1 New Married 2 Married ō ģ 2 No Yes Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Blac "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working should be filed within 72 l h and Mental Hygiene. I is marked other than "r traumatic event, the Med life. BQ NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Eather's Name (First, Middle, Last, 18. Mother's Name (First, permit. Page 1 and 2 should be Department of Health and Menta Important. If item 27 is marked any injury over 11. 2 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number Baltimore, 20b. Place of Disposition (Name of demetery, crematory or other place) isposition Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear vailure. List only one cause on each line. Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injurthat initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): attending physician of for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) signed by the and do not be detached for g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Ninknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has page 2 autopsy perform 2 🗌 No Yes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ဂ္ 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined cal Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on-29b. Signatu 29d. Date signed (Month, Day, Year) 5 2 2 2012 DOD66588 (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deatl Physician/ Medical 4c. County of Death
Baltimores 4a. Facility Name (if not institution, give street and number, Examiner Town, or Location of Death Randallstown Northwest Hospita 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday, Jamarco **Director** 28a-f show 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore MD Baltimore 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3419 21207 USA Yataruba Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) t of Health and Mental Hygiene.

If item 27 is marked other than or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Sinai Hospital Medical Technician 12th grade Be 17. Father's Name First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) မ Melbaume MyrHe Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore MD Dive Alvin McDunald Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 9 Department of Important; If any injury or 05/29/2012 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) permit. C. Greene Fungral Services 21. Signatura of Funeral Service Licenses - Facility yaugh o Road Landailstenn MD 21133 23a. Part 1. Enter the di shock, or heart fall Immediate Cause (Final ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate lure. List only one cause on each line Physician. disease or condition Medical resulting in death) ue to (or as a conseque **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ To the Hospital or Attending Physician: The law requires that the death signed by the atter in the past 12 months? Month Pregnant at time of death 9 🗌 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 1 Yes page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsv performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 2 🗌 No ☐ Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 205 auraltar 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mary L. McCarthy Physician/ 2017 45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital N/A Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Country 214-24-1729 Director 1 □ M 2**XX** F MD Sept 4, 1927 Usual Residence of Decedent 28a-f show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 4129 Falls Road 21211 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural any injury or other traumatic en-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XXNo Black White etc. Never Married 2 Married þ 1 ☐ Yes 2XXNo Specify. Ves Give Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) Self-Employed Caretaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Helen Gill Peter Joseph McCarthy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey McCarthy (Sister) 3132 Chestnut Avenue Balto,MD 21211 Method of Disposition

We have a substitution of Disposition of Di 20b. Place of Disposition (Name of 20c. Location - City or Town, State Meadowridge Memoria! Park 5/26/2012 Elkridge, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21. Signature of Juneral Service 3631 Falls Road Balto MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physicin disease or condition day Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a conse if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events Due to (or as a consequence of). resulting in death) Last been signed by the attending physician should be detached for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 E FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? 2 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No filled in by the Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature May 13, 2012 30. Name and address of person o completed cause of death (Item 23a) (Type, Pring Nyuyen 261 MO 21218 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nancy Gail Miller 11:20 P M 05 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 05/28/1954 Days Hours **Director** 1 □ M 2 1 F 212-62-8230 57 Maryland Usual Residence of Deced 28e-f show 10a. State 10b. County 27 is marked other than "natural", or items 23e or 28e-f sho r treumatic event, the Medical Examer mant to profiled at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD **Baltimore** Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 111 Leslie Avenue 21236 **USA** 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 ₩ Widowed 4 □ Divorced Specify Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working should be filed within 72 hand Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Cashier Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health end Mental Important: If item 27 is response injury or other 27 is response. ည William Shipley Anna Weitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Perdue / Daughter 111 Leslie Avenue, Nottingham, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/24/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sorota Marshall Dove Maryland Cremation Services, PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) UTERINE CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir physician and s the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 signed by the attending p Id be detached for use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy NANCY MILLER in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 19 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, 2 No within 24 hours after death,

To the Funerel Director: After this certificate has been sig completely filled in by the funeral director, page 2 should to Completed 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 1 Yes ည 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License numbe 29d. Date igned/Month, Day, Year 2012 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad JONES, CRNP JACKIE 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State Registrar

12-03765 Octavia Miller Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hydiene

ctavia Miller		I- For State	tate of Maryland		tment of ificate of		Mental		eg. No.	012	1652
Physicia	n/	Registrar 1. Decedent's Name (First, Midd						2. Date of Dee Month	Day Yes	or	Time of Death 0109 hrs
Medical Examin		Octavia She		_		- City Taylor and	-action of D	May 17, 2	2012		71091115
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death St. Agnes Hospital 4c. County of Death Baltimore N/A									
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY)								Y) 9. Birthpla	ace (State or	
Director		212-19-3669	1 M 2 F	39	Yrs.	Months Days	Hours	Min. 03/04	/1973	Foreign Country	n MD
	Usual Residence of Decedent									140	d. Inside City Limits
any		10a. State 10b. County		10c. City, T	own or Location					- 1	Yes 2 No
Maryland 28a-f show d at once.	إذ		I/A		ва	1timore	<u></u>	1.	10g. Citizen of W		***
e Mary or 28a	Director	10e. Street and Number	-1- pd			21229	v I		U.S		
with the Maryland ns 23a or 28a-f sho be notified at once		5431 Whitlo	12. Was Deceder	nt Ever in U.S		Decedent of Hisp	anic Origin?	(Specify Yes or No	o- 14. Race	e - American	Indian, Black,
leath v	Funeral	1 XNever Married 2 1	Married Armed Forces	s? 2. No	If Ye	s, specify Cuban,	Mexican, Pu	erto Rican, etc.)	Whit	te, etc.	
after o	Ð.		ivorced If Yes, Give Year or Dates:			Yes 2 X No				Blac	
hours natur Exam		 Decedent's Education (So Elementary/Secondary (0-12 	111111111111111111111111111111111111111		16a. Decedent during mo	s Usual Occupations of working life.	on (Give kind DO NOT use	retired)	16b. Kind of B	usiness/indus	stry
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21215-0036 Juld be filed within 72 hours a Mental Hygiene. marked other than "natura c event, the Medical Exami	å	Jeffrey Mil			T			ora Sin		01.1.7	0-4-)
thoul ond N	잍	19a. Informant's Name/Relation Ty 1 Qwanda Br		er)	5431			d., Balt			
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	ł	20a. Method of Disposition		20b. P		Date	20c. Location				
TOFE ages 1 at of H t: If i	- 1	1 Burial 2 Crematic		olale	rematory or oth	• Park		05/24/12	Balti	more,	MD
Baltimore, permit. Pages I are Department of Hee Important: If ite Imjury or other tr	ŀ	21. Signature of Funeral Service Licensee Constitution Consti									
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Physician		23a. Part I. Enter the disease, of failure. List only one caus	se on each line.							1 8	pproximate Interval Between Onset and Death
xaminer	1	Immediate Cause (Final diseas or condition resulting in death)				lerotic	Cardio	ovascular	Disease	-	
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6 be execute ysician and burial - tran	誤	x UNPENDED				er me,g92	28 6-1	9-12 sm	23d Date o	1	
876(ifficate ng phy is the t		IF FEMALE: 23b. Was decedent pregnant in	the 23c. If yes, outcome the 1 Live birth			al death 3	Ectopic pr	egnancy	Month	Day	Year
Box 6876 e death certificate the attending phy ed for use as the	Physician/N	past 12 months? 1 Yes 2 ✓ No 9 U	Internation T	at time of dea	=	ner (Specify)			1		
. Bo he dea y the a	چ	Part II. Other significant cond	9 Ulikilowii		sulting in the u	nderlying cause d	iven in Part I	23e. Did	tobacco use cont	tribute to the	cause of death?
Division of Vital Records, P.O. Bital or Attending Physician: The law requires that the de its after death. *I Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached to	<u>る</u>	Obesity with							es 2 V No 3	Probably	y 4 Unknown
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COF law r has b e 2 sh	ם								ormed?	death?	oletion of cause of
Vital Recc grician: The lav his certificate ha		25. Was case referred to medic	cal			26.Place	of Death (Ch	neck only one)	2140	1 🗸 163	
Vita ysicial his cer direct	e Be	examiner? 1 Yes 2 No		ntient 2	ER/Outpatient	3 DOA	Other ₄ N	ursing Home 5	Residence 6	Other:	
Of ug Ph	n: To	27. Manner of Death	28a. Date of I (Menth, Day	njury y,Year)	28b. Time of Ir	1 1	y at Work?		how injury occur	rred	
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Divi cospital or a hours after uneral Dire		4 Homicide	Physician: To the best of	my knowleda	e death occur	red at the time, da	te and place	and due to the cau	use(s) and manne	er as stated.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detacted for use as the burial - transit	Medical		kaminer: On the basis of e	xamination an	d/or investigat	ion, in my opinion,	death occur	red at the time, date	e and place, and	due to the ca	ause(s)
≥ 295. Signature and title of certuler									29d. Date sig	ned (Month,	Day, Year)
		Outer Vas	the Jees		- 19	O.C.1	И .Е.		May 18, 2	012	
		30. Name and address of person				Raltimere C	treet Balt	imore, MD 212	223		
21		Victor Weedn MD JD 31. Date filed (Month, Day, Yea.	1 2 2 2	trar's Signatu	re		neet, Dall				
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OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 01:30 AM O'Connor May 2012 Kenneth Francis Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Belair 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 215-16-1230 Director 1 💢 M 2 🗆 F 89 Feb. 05 1923 MD Yrs 10d. Inside City Limits 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director must be notified 1 ☐ Yes 2X No Anne Arundel Pasadena 28a-f Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 23a Funeral 1203 Hillside Road 21122 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Specify. 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Mechanic Auto Body & Fender Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည O'Connor Iona Holmes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jay O'Connor Baltimore. MD 21206 (son) Willow Avenue. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 31 Burial 2 Cremation 3 Removal from State May Donation 5 Other (Specify) Elkridge, Maryland Meadowridge Cemetery 21. Signature o Funeral e n e Licens e Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one day expressions. 23a. Part 1. Enter the disea Immediate Cause (Final Physiciani disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 🖢 No 1 Inpatient 2 ER/Outpatient 3 DOA ျ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completely filled in by the funer Natural 5 Pending Investigation Accident 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Frauttioner. To the best of my the vising a continuous at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) oper chosupealed Drue Bel Air MD 21014

DHMH 17 Rev 06-2011

State Registrar 31, Date filed (Mo

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Manth 19^{pay} 2012 5:20 A M Physician/ MICHAEL COHNITZ OLSHAUSEN Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. (Month, Day, **Funeral** Min. Hours 1 **X** M 2 □ F Michigan 1946 June Director 364-52-5665 65 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State the Maryland ms 23a or 28a-f sho must be notified at Director 1 Yes 2 No North Bethesda Montgomery MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ge 1 and 2 should be filed within 72 hours after death with 1 to f Health and Mental Hygiene.
If item 27 is marked other than "natural", or ihare or or other traumatin parts. United States 20852 10401 Grosvenor Place #804 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 X Never Married 2 Married Yes 2 XNo þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Specify: Caucasian 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Journalism Writer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Gabriele Charlotte Cohnitz Joern Justus Olshausen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7105 Whittier Blvd. Bethesda, MD 20817 Jeffrey Anderson / Executor 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State Department of Important: If any injury or once. Woodbine, Maryland 5/24/2012 4 Donation 5 Other (Specify) Journey Crematory Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M 21. Signature of Funeral Service Licer MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GASTROINTESTINAL BLEEDING Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MONTHS GRAFT VERSUS HOST DISEASE Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events YEARS Exam CHRONIC MYELOMONOCYTIC LEUKEMIA Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b, Was decedent pregnant Ectopic pregnancy Day in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown CHRONIC RENAL FAILURE Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy has performed page 1 Yes 2 X No certificate I 1 X Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be miner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA ᅆ After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27. Manner of Death Certificate: iniury 1 🔼 Natural 5 Pending Accident Investigation Director: / 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hin 24 hours a the Funeral D npleted filled Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature title of certifi 29c. License number MD-12817 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 DANIEL S. CHERTOW 31. Date filed (Month, Day, Year, 32. Registrar's Signature State MAY 2 4 2012 sark

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 23, 2012 CECIL FREDERICK OLIVER 2:20 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST CENTER TOWSON BALTO. 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Director 216-32-9984 74 1 XM 2 F 6-14-1937 **MARYLAND** Usual Residence of Deceden 28a-f show 10a State 10b. County ?7 Is marked other then "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 💥 No HARFORD MD. FALLSTON 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? **504 AUBURN COURT** 21047 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 2 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Completed 3 Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with nend Mental Hygien 7 Is marked other ti ELECTRICIAN WESTERN ELECTRIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CECIL F. OLIVER AGNES JELNICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 end 2 s of Health item 27 l **SPOUSE** ROSE M. OLIVER **504 AUBURN COURT** FALLSTON, MD. 21047 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Pege 1 e Depertment of H Importent: If ite any Injury or ot 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State ATLANTIC CREMATORY 5-25-2012 GLEN BURNIE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BEL AIR 610 W. MACPHAIL ROAD BEL AIR, MD. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death Physician/ Dementio Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): death certificate be executed attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Þ Records. Completed iscase 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page perform 1 ☐ Yes 2 ☐ No of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes Other: ည 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSALCE e Hospital or Attending P n 24 hours after death. e Funeral Director: After ti 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending Division 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Exam uner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ar certifier 29d. Date signed (Month, Day, Year) T8211000 ss of person who completed cause of death (Item 23a) (Type, Print) Will Shaheen, 6701 N. Charles #4105, Baltimere, MD 21204 31. Date filed (Month, Day, Year) State MAY 2 4 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16527 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY 20^{Day}2012 GARFIELD POTTS 9:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 1 🔀 M 2 🗆 F 218-24-9906 82 Aug. 17, 1929 Maryland 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 81 Main St. 21793 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 X Married 1 X Yes If Yes, Give 2 No be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates. 1951-53 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 civilian contractor Federal gov't. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Howard Edward Potts Mary Anders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant: If item 27 i Betty Potts/ wife 81 Main Walkersville, MD 21793 St. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 5/24/2012 Walkersville, MD 21. Signature of Funeral Service Lipens 22. Name and Address of Facility Hartzler Funeral Home, P.A. 404 S. Main St. Woodsboro, MD 21798 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No After this certificate 2 No 1 Tes Division of Vital completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: မ 1 XInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of al or Attending F s after death. I Director: After Certificate: 28c. Injury at 1 Natural (Month, Day, Year) 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Funeral Medical 29a. Certifier 1 Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29c. License number 12012 MDD35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Myung Hee Nam

Frederick. MD 21701

400 W

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kathryn Elizabeth Pennington May 2012 4:55 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot 1615 Chancellor Point Road Trappe Social Security Number Age (In yrs. last birthday) Year If Under Days Hours 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min Oct 6, 1933 Country) DC: 577-46-1022 78 **Director** 1 🗆 M 2 🕡 Yrs ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits with the Maryland 10a. State 10c. City, Town or Location Director 1615 Chancellor Point Road **Talbot** 1 🗆 Yes 2 🗖 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1615 Chancellor Point Road U.S.A. Funeral 21673 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 No Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White If Yes Give Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kathryn Julia Kalkowski Albert C. Dansereau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1615 Chancellor Point Road Trappe, MD 21673 Don Pennington Spouse 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Memorial Gardens May 25, 2012 Marriottsville, Maryland 5 Other (Specify) Fungral Service Lice 22. Name Salack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Sipratura M00535 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Final Physician/ hease or condition resulting in death) Flate Medical Due to (or as a consequence of) Examiner cushfield list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Pregnant at time of death Other (specify) Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page this certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \mathbf{x} Residence 6 \square Other (Specify) 1 🗆 Yes 2 No ည ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work thours after death.
uneral Director: Aftely filled in by the ful 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 06-2011 Mark

31. Date filed (Month, Day, Year)

408

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 per FH C927 5/24/2012 JH State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last 2. Date of Death 3. Time of Death Physician/ Month 9:18 AM Ilmer Medical Eacility Name (if not institution, give street and number) County of Death Examiner Himore Ba, 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Hours 61 Yrs. Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No 5 10e, Street and Numbe 10g. Citizen of What Country? 23a Funeral 21117 cash death v or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify and Mental Hygiene. is marked other than "natural", Completed 3 Widowed 4 Divorced Blac 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ice Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ္ 19a. Informant's Nan e/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mills MD 21117 Baltimore, Method Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cr 4 ☐ Conation 5 ☐ Other (Specify) Signature of Funeral Service Ligensee ene Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence bf): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine ng physician and as the burial-tran Due to (o as a consequence of): attending physician for use as the burial Physician/Medical requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) been signed by the should be detached Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law After this certificate has page 2 autopsy performe 1 Yes 2 No Division of Vital 25. Was case referred to medica the funeral director, 26. Place of Death (Check only one) Be examiner' Hospital Other: 1 Yes 읻 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fi Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) 2016 38. Name and address of person who completed cause of death (Item 23a) (Type, Print) O 31. Date filed (Month, Day, Year) State 2 4 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 20b per 1h 9927 5-24-12vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) ate of Death Physician/ ROWLE Medical 4b. City, Town or Location of Death stitution, give street and number, 4c. County of Death Examiner Baltin 12 and all stown thwest Hospice If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthplace (State or Foreign 7. Age (In vrs. last birthday, **Funeral** Days (Month, Day, Year) Director 1 M 2 X F MO 08 1930 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NIA Baltimore 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21215 Avenue 2604 Dakler USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: 3 ₩Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Department of (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Social Services 12tharade Home Health Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Murtle Flamina Robert Johes 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Parsons Lane Havre de Grace, MD 21078 Daughter Sandy CIVIS 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Greenmount Crematory 5-25-12 22. Name and Address of Picility Vaughn C. Greene Funeral Serves 21. Signature of Funeral Service Licensee 8728 Liberty Road Randaliston, MD 21133 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a con quence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it 1 🔲 Yes Yes 26. Place of Death (Check only one) filled in by the funeral director, 25. Was case referred to medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work? 1 Yes 28d. Describe how injury occurred injury 5 Pending 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Date filed (Month, Day, Year State 3 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH G930 8/16/2012 JH. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year WILLIE RAGSDALE 6510M Medical 12 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MERCY CENTER BALTIMORE MEDICAL Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country)
 T7A 1 XM 2 - F Months Davs Hours Director 228-48-4375 71 6/12th 1940 (ear) Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits MD n/a Baltimore 1X Yes 2 □ No 10e. Street and Number . Hygiene. other than "natural", or items 23a or rent, the Medical Examiner must be I 10f. Zip Code 10g. Citizen of What Country? Funeral 218 N. Charles Street 21201 USA death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force 5 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 Specify African-American 1 Tyes 2 No Specify 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) John Hapkins School of Medicine Bio Medical Photographer permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important. If item 27 is marked other i any injury or other traumatic event. the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charlie Ragsdale Annie Pearl Holmes 193 teven kefthokagsdare/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Regodale/ Son 8446 Each Leaf Court, Columbia. MD 21045 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place 5-27-2012 Rose Bud Cemetery Kenbridge, VA faFun ral Sex i 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sicia / Onset and Death disease or condition resulting in death) PULMONRY EMBOLISM Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed burial-transit se (Disease of Infilial) that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Ectopic pregnancy for Pregnant at time of death Month Dav Year the be detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? page 2 🗌 No Yes 2 No 1 Yes Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No မ 1 Inpatient 2 K ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Matural s after death.

I Director: Aff
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital c 24 hours a 24 hours Medical 29a. Certifier K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 7/2009

State

Registrar

PITCE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEE

MAY 2 4 2012

Date filed (Month, Day, Year)

301

ST

32. Registrar's Signature

5/18/2012

DM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2012 Year Physician/ William Wesley Rose 21 6:30 P M May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Parkville Baltimore 8113 Hillendale Road Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Month, Day, Hours 1 XM 2 - F Months 69 527-60-4392 Washington, DC Director 1942 Nov. Usual Residence of Decedent 28a-f show 10b. County notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 ☐ Yes 2 🏻 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ian "natural", or items 23a or Medical Examiner must be Funeral 21234 8113 Hillendale Road USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 ☐Xio Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) C. Hoffberger Company the Mechanic/Supervisor 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o ည Mildred Evelyn Hayes William Arnold Rose other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 shat of Health a 8113 Hillendale Road-Parkville, Maryland 21234 Beverley Rose-Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery crematory or other place) zans Fureral Chapel d Cremation Ser. Belair Department of Important: If it any injury or c 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mau Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last sician a burial-1 Physician/Medical Box 68760 phys attending philips for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown Yes 2 No g Unknown P.O. I signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performe this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be Hospital 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of To the Hospital or Attending Plantin 24 hours are death.

To the Funeral Director After the completed filled in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 \square Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salome D 2/328 31. Date filed (Month, Day, Yea 32. Registrar

State

Registrar

MAY 2 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ PAUL J. REDMOND 2:05 P MAY Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death GILCHRIST HOSPICE TOWSON BALTO. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year 218-54-1938 1 XM 2 D F 63 Director 12-7-1948 MARYLAND Usual Residence of Deceder 28a-f shov 10b. County 10a. State Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits **JOPPA** MD. BALTO. 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1102 JANICE COURT 21085 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 2 "natural", or 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: WHITE Completed 3 Divorced 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) LAWYER SELF-EMPLOYED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked of ည GEORGE REDMOND ALVINA BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i BROTHER 1763 CHRISTIANA DRIVE FINKSBURG, MD. 21048 TIMOTHY J. REDMOND 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) HIGHVIEW 5-25-2012 FALLSTON, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BEL AIR 610 W. MACPHAILROAD BEL AIR, MD. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ MUCHOMA moran s Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records. No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural Accider 5 Pending death. 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation after deat Director: the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or A within 24 hours after To the Funeral Dires completely filled in b Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOZWOT

State Registrar

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. lend item 30 per dyr 9927 5-24-12 yt. State of Maryland / Department of Health and Mental Hygiene For State Registrar 16534 Certificate of Death 's Name (First, Middle, 2. Date of Death 3. Time of Death Physician/ Month 0.5 55 PM Medical 4a. Facility Name (if not institution, Examiner 4c. County of Death Monts 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Brocklyn **Funeral** If Under 24 Hrs. **X**M 2 □ F Hours Min. Director Yrs 28a-f show 10a. State with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No 995C ö 10g. Citizen of What Country? Funeral 23a items 2 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. ٥ 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 54185 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maider မ traumatic 19a. Informant's and Number or Rural Route Number. Cita 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Method of Disposition 20b. Place of Disposition (Name of Location Date Burial 2 Cremation 3 Removal from State
Comparison 5 Other (Specify) Signature of Fune al Service License 22. Name and Add Tools 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause yeach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a cor been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy perform 2 No 2 No 1 🗌 Yes 1 Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 ▼ Nursing Home 5 □ Residence 6 □ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of rtifie 29d. Date signed (Month Day, Year) 2012 le 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan J. Miller 8218 Wisconsin Ave #305 Bethesda, Md. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 24 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Giulietta Rosselli Month 4 4:40 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE OWSON Funeral If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 15, 1920 9. Birthplace (State or Foreign 214-46-9521 **Director** Italy 1 🗆 M 2 🔀 F 92 Usual Residence of Decedent 10a, State 10c. City, Town or Location Director 10d. Inside City Limits notified MD Baltimore Lutherville-Timonium 1 🗆 Yes 2 ื No 10e. Street and Number ō 10f. Zip Code ms 23a or must be 10g. Citizen of What Country? Funeral 1502 Dulaney Valley Road 21093 U.S.A. 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hairdresser Hair/Beauty Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Angelo DaCampo Angela Campo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code)
1502 Dulaney Valley Rd., Lutherville, MD 21093 Health tem 27 Sebastian Rosselli-son Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Nother (Specify) Entombrent Parkwood Cemetery 5/29/12 Parkville, MD 21. Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MYOCARDIAL Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No 1 Yes 2 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by CONGESTIVE HEART FAILURE 1 Yes 2 No 3 Probably 4 Unknown CEREBROVASCULAR ACCIDENT 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗶 No မ 1 Inpatient 2 K ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 \square Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the basis of my knowledge, due to time date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination allow introduced and Certifying Nurse Practitioner: To the best of my knowledge, but it 29b. Signature and title of certifier D64300 antey Rountel, no. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON MARYLAND 21204 ROSENTHAL, M.D.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1617 Physician/ RIFAT, SULTANA 2012 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CENTER BALTIMORE UNIVERSITY OF MARYLAND MEDICAL If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 220-94-3676 57 **Director** 1 🗆 M 2 🗶 F 12/22/1954 Bangladesh Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State at should be filed within 72 hours after death with the Maryland Director Prince Georges items 23a or 28a-f s ner must be notified Md. Hyattsville 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 4410 Oglethorpe St. 20781 Bangladesh Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ı "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 X Divorced asian Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medic (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sociologist Sociology 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zerina Sultana Abdur Rahman 19a. Informant's Name/Relationship (Type, Print) SONINI a W 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20781 4410 Oglethorpe St. Apt706 Hyattsville, Md. Mohammad Shahriar Momin 20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland National 5/15/12 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Laurel, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Universal Mortuary Signature of Funeral Service Licensee 411 Kennedy St NW Washington, DC 20011 A 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician. SCHEMIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examine If any, leading to immedicause. Enter Underlying Cause (Disease or injury URINARY TRACT the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed page 2 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 X Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) ours after death.

leral Director: Aft
filled in by the fur 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

29b. Signature and title of certifier

DILJON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NP1: 1184883217

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Snyder Mary Ann 10.27 A M MAT 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MACHINGTON MEDICAL CENTER MURNIE AHH SALTIMORE CHEN If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Min. 213-30-0512 Director 1 🗆 M 2 🔀 F Feb. 11 MD 1933 79 Yrs. Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27s marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Anne Arundel Severna Park Maryland 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? USA Funeral 21146 275 W. Capote Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2X Married Yes 2 X No Yes, Give 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White should be filed within 72 hours afte and Mental Hygiene, is marked other than "natural", Specify 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Cosmetology Beautician 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tomich Anna Leonard DeFontes VITVER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 275 W. Capote Court, Severna Park, MD 21146 Franklin Snyder (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20a. Method of Disposition 20c. Location - City or Town, State May^{Date} 23 1 Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) Baltimore, Maryland 2012 of Funeral Servi 21. Signatur 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadaena, MD 21122 eations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part 1. Enter the disease, or composhock, or heart failure. List only does Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTA Physician/ disease or condition resulting in death) Medical TEAR **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical death certificate be P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at Id be detached fr 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 Yes 2 No 3 Probably Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? To the Hospital or Attending Physician: The law r within 24 hours after death, To the Funeral Director: After this certificate has b autopsy filled in by the funeral director, page 2 performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 □ Yes 2 □ No 28b. Time of 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 🗌 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely only one) 29d. Date signed (Month, Day, Year) re and title of certifier 29c. License number 29b. Signatu 4514 Ma 1210 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Flen Burnce 2016.1 SABAI 301 TILE Hospital 31. Date filed (Month, Day, Year State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Peter Karl Schenck, Ph.D. May 2012 27 3:45 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore County 1504 Providence Road Towson Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days 123-36-3229 66 **Director** 1**X** M 2 □ F Oct. 09,1945 Queens, New York Usual Residence of Decedent 28a-f shov 10a. State must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Maryland Baltimore County Towson 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1504 Providence Road 21286 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 11. Marital Status 14. Race - American Indian. the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 80 Physicist N.I.S.T. Be and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of Arthur Eugene Schenck Helen Marie Kramer 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Mrs.Elizabeth(nee Hauser)Schenck 1504 Providence Road Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, State (Harford County) cemetery, crematory or other place)

Evans Funeral (hapel and Cremation Services, Inc. 1 Burial 2 Cremation 3 Removal from State Thursday 4 ☐ Donation 5 ☐ Other (Specify) May 24,2012 Forest Hill, Maryland 21. Signature of Funeral Service Licensee Leffrey L. Gair, Sr. O.S. 22 Name and Address of Facility was Funeral and Cremation Center, P.A. M Lic.#M00677 2325 York Road Timonium, Maryland 21093-2215 inter the disease, o , or leart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatio disease or condition One month Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to for as a consequence of If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-tra Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the hum Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 4 🗆 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0055301 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Suit 5100 Charles 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1849 M 2012 Beach Clark Stong Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll <u>Carroll Hospital Center</u> Westminster **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Hours Min. (Month, Day, Year) Director 204-22-0166 1 □XM 2 □ F 83 Feb. 28,1929 GA Usual Residence of Decedent 28a-f shov 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland irector 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🗓 No Carroll MD Union Bridge ä 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4210 Bark Hill Rd 21791 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates.1950—1952 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ፩ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) independent trucker transportation Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 Is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eula Mae Clark Albert Harrison Stong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Mary E. Stong/ sister 4210 Bark Hill Rd. Union Bridge, MD 21791 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stong Family Cemetery 5/23/2012 Union Bridge, MD 22. Name and Address of Facility Hartzler Funeral Home, P.A. 21. Sign num of Funeral Service Licenses (athanie box 249 New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that carsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ ardiac disease or condition Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): **burial**resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 Probably 4 Unknown been signal 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this c Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 V Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation
6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

Mariaune 20+45Child M.D. 8002 B L Dollyhyde Rd. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

2 4 2012

12-03852 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 16540 Judith Ann Shinogle State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Day May 20, 2012 Medical Examiner 0641 hrs Judith A. Shinogle 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Hours Director 510-72-0704 Country) Kansas 1___ M 2 **y**F Jan. 25 1963 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location Wash.DC Washington DC 1 Y Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1801 Potomac Ave. S.E. 20003 IISA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 3 Widowed 4 Divorced If Yes, Give Yeer Yes 2 X No specify: Specify: white ੬ 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Education Professor 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Shinogle Louise Van Nahmen ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7609 Northwest Roberts Rd., Weatherby Lake, MO 64152 Robert L. Shinogle/brother nt of Health ant: If item 27 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department or Impartant: I 5/22/12 Atlantic Crematory Glen Burnie, MD 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lemmon Funeral Ho 0 W. Padonia Rd., Home of Dulaney Michael 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and or use as the burial - transi The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. δ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' ✓ Yes 2 No 1 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital Be Other₄ Nursing Home 5 Residence 6 Other: DOA 1 Yes 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification May 20, 2012 Subject driver struck head-on by vehicle in Natural 0634 hrs 5 Pending 1 Yes 2 ✓ No the hours after death wrong lane 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) NB-Baltimore Washington Parkway N of 193, Greenbelt, within 24 hours a determined (Specify) Major Road / Highway Homicide 29a, Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DHMH 17 Rev 1/2001 OCMF 2006

State Registrar

ORIGINAL

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

DOME

Victor Weedn MD JD

31. Date filed (Month, Day, Year)

lead

Assistant Medical Examiner

32. Ragistrar's Signature

29c. License number O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

May 21, 2012

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6 OCAM LaKesha 22 Tate Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN Saucie Baltimore HOSPITa Rosedal If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Months Hours Country) 07-08-83 28 MD) 213-04-1603 Director 1 M 2**XX**F Usual Residence of Decedent marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 X Yes 2 ☐ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2019 Dundalk Avenue 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. African þ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: American 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Dental Hygienist School other traumatic event, the 12th Grade Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Tate Demontagnac Marvin G. Lorraine permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 724 Greenwood Road Pikesville, Maryland 21208 Marvin G. Tate-Father 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 $\stackrel{K}{\boxtimes}$ Burial 2 $\stackrel{\square}{\square}$ Cremation 3 $\stackrel{\square}{\square}$ Removal from State 05-30-12 Arbutus Mem. Park Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure, List only one cause on each line Immediate Cause (Final Tampona Phytician. cardiac disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner icadit Sequentially list conditions, trany leading to himselfate cause. Enter Underlying Cause (Disease or injury Erythe mat osus use as the burial-transi stemic that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ o in the past 12 months?

1 Yes 2 No Month Pregnant at time of death signed by the at d be detached for 4 ☐ Pregnant a
9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? page 2 s death? Director: After this certificate I or Attending Physician: after death. filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 120067697 0600 address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIH SQUERCE 9000 DR Balto md Nelia 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	For State State Registrar	e of Maryla	_	rtment of H tificate of D		Mental Hy	giene Reg. No. 21	012 16542
Physicia	in/	1. Decedent's Name (First, Middle, Last) Grace Py	ourn Sto	okshorry			2. Date of De Month May 2.	ath Day	3. Time of Death 10:20 PM
Medic Examin		4a. Facility Name (if not institution, give street and	OKSDEITY	4b. City, Town, or Location of Death			4c. County of Death		
Funeral	17	Montgomery General Ho 5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year	ney If Under 24 Hrs.	8. Date of Bir	th	g. Birthplace (State or Foreign
Director		461-78-2317 1 □ M 2 2	90	Yrs.	Months Days	Hours Min.	June 4,		Country) Texas
and show	ř	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loc					10d. Inside City Limits
e Maryl 28a-f notified	Director	Maryland Montgomery 10e. Street and Number		Ga	ithersbur	g	Т	10g. Citizen of	1 X Yes 2 No
with the 23a or sst be	Funeral [301 Russell Avenue #2	17B		2087	7		United	
15-UU36 72 hours after death with the Maryland n'natural", or items 23a or 28a-f sho dedical Examiner must be notified at		Arme	Decedent Ever in	U.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		ce - American Indian, ck, White, etc.
USO rs after rral", o	ed by	If Yes	Yes 2 🐼 No s, Give or Dates.	1	☐ Yes 2 🖾 No	Specify:		Specify	White
Z15-UU36 in 72 hours after e. nan "natural", o Medical Exam	Completed	15. Decedent's Education (Specify only highest grade comp		(Give I	lent's Usual Occupa kind of work done d O NOT use retired)	ation Juring most of wor	king	16b. Kind of E	Business/Industry
Z1Z Within within giene. Ser than than the M		Elementary/Secondary (0-12) Colle 5	ge (1-4 or 5+) 		nool Teac			Educa	
very series	To Be	17. Father's Name (First, Middle, Last) James Martin Pyburn				18. Mother's Nar	me <i>(First, Middl</i> e, nia Schi		e)
ore, Maryiat 1 and 2 should be of Health and Ment item 27 Is marked r other traumatic e		19a. Informant's Name/Relationship (Type, Print)			ng Address (Street a				
and Heal		Linda S. Wyatt/Daught 20a, Method of Disposition		b. Place of Dispo		Drive,	Rockvil		yland 20852 - City or Town, State
more		1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State M	cemetery cren ontgomen	Lum, Inc.	^{e)} May 2		I	la, Maryland
Baltimore, permit, Page 1 and Department of Hea Important: if item any injury or other once.	- 31	21. Signature of Fungral Service Licensee	M00				Funeral	Home/Ro	ckville, Inc. e, Maryland 20850
		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the d	leath. Do not ente	er the mode of dying	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
C Physician/		Immediate Cause (Final disease or condition	cute	Cere	brovasi casdia	ular	acci	dent	Onset and Death
Medical Examiner		resulting in death) Di	ue to (or as a cons	sequence of):	casdia	(iu	forcti	on	
T	Examiner	cause. Enter Underlying	ue to (or as a cons	sequence of)					
xecuted n and al-trans	Exan	Cause (Disease or injury that initiated events c. ———————————————————————————————————	ue to (or as a cons	sequence of):					
60 ate be executed hysician and the burial-transit	dical	d							
		IF FEMALE: 23c. If ye	s, outcome of pre	gnancy				23d. D	eate of delivery
, P.O. Box 68760 ss that the death certificate be executed igned by the attending physician and be detached for use as the burial-transi	Physician/Me	in the past 12 months?	Pregnant at time Unknown		☐ Ectopic pregnand ☐ Other (specify)			N	lonth Day Year
P.O. that the ned by the detach	y Phy	Part II. Other significant conditions contributin	g to death but not	t resulting in the u	underlying cause giv	ven in Part I.			ntribute to the cause of death?
dS, F quires then significant to the significant to	d pa						1 🗆		3 ☐ Probably 4 ☑ Unknown
law rec	Completed by						24a. Was auto per	s an 24b opsy formed? 2 No	. Were autopsy findings available prior to completion of cause of death?
al Re an; The tifficate tor, pag	Be Co	25. Was case referred to medical			26. P	ace of Death (Che		2 MNo	1 Yes 2 No
f Vita	은	examiner? 1 Yes 2 No Hospital:		2 ER/Outpatie		4 L Nursing	T	how injury occu	
on of	cate	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	Date of injury (Month, Day, Year		work	y at <br Yes 2	Zed. Describe	now injury occu	neu .
Division of Vital Records, tal or Attending Physician: The law requires is after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be an income.	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - A building, etc. (Spe	At home, farm, str ecify)	eet, factory, office		28f. Location City or To	(Street and Num own, State)	ber or Rural Route Number,
	Medical (29a. Certifier 1 Certifying Physician: To (Check 2 Medical Examiner: On the control of the contr	he hacis of examin	ation and/or inves	stigation in my opini	on, death occurred	at the time, date	and place, and c	tue to the cause(s) and marmer stated.
To the Hos within 24 ho To the Fund completely	Me	only one) 3 Cettifying Nurse Practi	tioner: To the best	t of my knowledge	e, death occurred at 29c. Licens	the time, date and	place, and due to	the cause(s) and	manner as stated. ned (Month, Day, Year)
		> James	И,	D	60	999		5/1	12/12
201		30. Name and address of person who complete	d cause of death ((Item 23a) (Type, 1201	_{Print)} Seven Loc	ks Road	, Rockvi	11e, Ma	ryland 20850
Sta Regist	ate	31. Date filed (Month, Day, Year) MAY 2 4 2012	32. Registry 's Si		,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 0630AM 5 **Physician** TRENUM GERALD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WESTERNPORT ST. HAMMON) APT 308 ALLEGANY Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Funeral 1 M 2□ F Months Days Hours 219-34-6206 01/20/1939 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 28a-f show th and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-1 show traumatic event, the Medical Exposition to most be profiled at WESTERNPORT 1 ☐ Yes 2 No ALLEGANY **Funeral Director** MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21562 HAMMOND ST, APT 308 U.S 421 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. Pages 1 and 2 should be filled within 72 hours after 1 Never Married 2 Married Yes 2 Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. Specify: WHITE Completed by 3 Widowed 4 Divorced GUARD 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Mining 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lonzy Trenum ပ Madeline Yutzv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is any Injury or other trausonce. Betty J. Reid / Daughter 3204 A Wheaton Way, Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 5/23/2012 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Marshall Dorota Marshall Dolote Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RENAL DISEASE YEAR **Physician** STAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending n 24 hours after death.

e Funeral Director: Aft bletely filled in by the fun investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RO95622 CRICA 30. Name and address of person who completed cause of death (Item/23a) (Type, Print) 1313
KATHERINE A. MCKENNEY CRNP LAVA 1313 NATIONAL HIGHWAY LAVALE, M.D. 21502 241

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 16544 L. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KATELYN TONEY Month 2012 M. 7:30 A M MAY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 04/15/1991 **Funeral** 9. Birthplace (State or Foreign Hours Director 1 - M 2 F 186-72-6516 21 Pennsylvania or 28a-f show il Hygiene. I other than "natural", or items 23a or 28a-f shoi vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N☐ Yes 2 ☐ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 369 S. Cannon Ave 21740 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: 3 Divorced 4 Divorced Specify Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H 7 is marked of Bruce Sean Toney Sharon Martinez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Bruce Sean Toney / Father 421 N. Church St., Waynesboro, PA 17268 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 5/23/2012 Beltsville, MD Signature of Funeral Service Licensee Dorota Marshall () Ou Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ acrete Medical Examiner Chumunon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Examiner Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year ☐ Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 Ø No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🗹 No မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 800 ORLEANS ST BALTIMORE, MD 21287 31. Date filed (Month, Day, Year) State MAY 2 4 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State Amend Item 25 State of Maryland / Department of Health and Mental Hygiene 20 State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 16545 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Else G. Varner 12:05 AM mAY Medical 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospital Baltimore alt more Varne Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) 521-56-3643 Director 1 □ M 2 □X 2-25-1940 West Prussia Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10h County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD. Baltimore Lochem 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2020 Featherbed Lane, Apt. 322 21207 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married 1 / 1 1 σ ως α ς Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: German 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+ Homemaker Danestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev 2 George Renner Anna Pieletzki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David A. Varner/Son <u>3602 Sylvan Drive, Lochem, MD 21207</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Neurial 2 Cremation 3 Memoval from State 4 Donaylon 5 Other (Specific Woodlawn Cemetery 5-18-2012 Woodlawn, MD Signature of Funeral Se 22. Name and Address of Facility Whie Funeral Home P.A. Of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph. sician macerbral disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last CERT Due to (or as a consequence of): signed by the attending physician a d be detached for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be.
 Lours after death.
 Funeral Director: After this certificate has been signed by the attending physicis et elety filled in by the funeral director, page 2 should be detached for use as the but. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 2 No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical within 24 hou

To the Funer

completely fil 29a. Certifier Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29c. License number 29d. Date signed (Month, Day, Year) D4.7683 Taymong Miller 13/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

Raymond Miller

31. Date filed (Month, Day, Year)

NAY 2 3 2012

MD

21117

Box

3 Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16546 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19^{Day} Physician/ Mary. 2012 5:07p M C. VanCamp Jeanne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min March 10, 1958 009-52-1299 Director 54 Wisconsin permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits 10a, State Director Baltimore MD Essex 1 Yes 2 KNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21221 2221 Corscia Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Armed Forces? Black White etc 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 M Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Educator Educator Rehab. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacqueline Grassel James E. Paasch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5200 Stonewick Drive Glen Allen VA 23059 Timothy Paasch /brother 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Bayview Crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5/25/12 Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave. 21. Sign and of Funeral Service Coenses Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) a. MYOCARDIAL INFARCTION Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Records, P.O. Box 68760 JEANNE VANCAMP IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 💹 No 4 Pregnant at time of death 9 Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 2 200 3 Probably 4 Unknown 1 Yes been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy has 1 ☐ Yes 2 ☐ No certificate Yes 2 X No **Division of Vital** or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) HOSPICE 1 🗌 Yes 2 X No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) CRNP 2300 DULANEY VALLEY RD. JACKIE JONES, TIMONIUM, MD 21093 31. Date filed (Month, Day, Year MAY 2 4 2012 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16547 State Registrar Certificate of Death 2. Date of Death Physician/ Month May 2012 William Daniel Wilkerson, Jr. 4:25 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harmony Hall Assisted Living Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Min. (Month, Day, Year) **Director** 213-12-8871 1**x**x M 2 □ F 90 May 11, 1922 Maryland Usual Residence of Decedent 28a-f show 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Howard Columbia 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code d Mental Hygiene. marked other than "natural", or items 23a or matic event, the Medical Examiner must be r 10g. Citizen of What Country? Funeral 6336 Cedar Lane Apt 378B 21044 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates. Army White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Draftsman Ship Building Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Daniel Wilkerson Charlotte Westermeyer 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, Maryland 21044 Patricia Wilkerson (Daughter) 10320 Wilkelake Terrace 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of F
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley 5-26-2012 Timonium, Maryland 22. Name and Address of Facility 21. Signatur Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-t resulting in death) Last physician Physician/Medical as the that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ó in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death 1 Yes 2 No ed by the a detached t 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by be Division of Vital Records, or Attending Physician: The law requires Completed been signated by the second of 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an has autopsy performed? 1 Yes 2 No page 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted Living Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗶 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending injury of thours after death.

Funeral Director: Af oldered filled in by the funeral funeral funeral funeral filled in by the funeral function functio death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital Medical 29a Certifier 1 🔀 Certifying Physician: he bit of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner Medical Examiner: In the balls of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse, ractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) S D47447 May 23, 2012 30. Name and address of par on who comal ted cause of death (Item 23a) (Type, Print) 6334 Cedar Lane #103 Andrew Lazris Columbia, Maryland 21044 31. Date filed (Month, Day Year)
MAY 2 4 2012 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 23^{Day} Physician/ 5:30 MaV Month 201^Y2° Rodnev Edward Wallace Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia 6283 Sunny Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 530-36-1459 Director 1 X M 2 - F 64 May 23,1948 Washington DC Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10c. City, Town or Location Director Columbia 1 Yes 2 No Maryland Howard the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21044 6283 Sunny Spring ral", or items 2 Examiner mus death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 X No þ 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 16b. Kind of Business/Industry Howard County Public Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Keitha Mae Dyer Edward Leroy Wallace f Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6283 Sunny Spring, Columbia, Maryland 21044 Leslie Wallace / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. 05/24/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland Inc. Signature of Funeral Service Licensee Alvson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complication hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) years **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death Other (specify) 9 Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Yes 2 N 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Tes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred X Natural injury 5 Pending Accident 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D71600 952 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Teiaswik. Saitry Mo 10710 Chart Columbia, 10710 Charter Z. Registrar's Signature State MAY 2 4 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 16549 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ :00 AM WOORUM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROL SVILL TREE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 M 3-05-815 Min. (Month, Day, Months Days Hours Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2- No WHITE "natural", 3 Nidowed 4 □ Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Fant: If item 27 is marked other than " Elementary/Şeconday (0-12) College (1-4 or 5+) WRAPPER 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ AUKEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARY WILLOUGHB Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other plan 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 30/2012 TIMONIUM, MO 21. Signature of Funeral Service Licensee UNZUMBRUN EHA MONCO 22. Name and Address of Facility SYFESVILLE RD EWERSBURG-MO 21784 28 Part Y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. One of and Death Immediate Cause (Final Physiciani allure disease or condition resulting in death) Medical Due to (or as a consequence of Examiner 6 month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury (ra) a consequence of) Examine Due to sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypothyroidism 1 = Yes Division of Vital Records, No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No this certificate Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26 Place of Death (Check only one) Certificate: To Be 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21784

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

MAY 2 4 2012

32. Registrar's Signature

0.0.0% Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 16550 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Madeline 2Ĭ 2012 Alta Whipp May 10:45 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Homewood at Crumland Farms Frederick Frederick Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) Funeral Days Min **Director** 215-14-2660 90 1921 4. Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at Directo 1 Tes 2 X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funera 7401 Willow Rd., Apt. 353 21702 U.S.A. "natural", or items 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No $0.D.\ \mathcal{S}/\mathcal{U}/\mathcal{A}_{0}$ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 11 icensed practical nurse hospital Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o မှ Wilfred G. Norris Edith Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or with 8550 Mapleville Rd. George Norris/ nephew Mt. Airy, MD 21771 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 5/25/2012 Frederick, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home, P.A. atharine 11802 Liberty Rd. LIbertytown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition 45 Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, Physicians as: Madeline Whyp Due to (or as a consequence of): if any, leading to immediate Exami Cause (Disease or iinjury that initiated events sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vifal Records, P.O. Box 6870 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 1 Yes 240 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate to the Funeral Director. 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 \(\sum \) Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D31058 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gene Ashe 0200 Coppermine Rd. Woodsboro, MD 21798 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16551 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marion D. Ward May 19 2012 11:30å Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. (Month, Day, Year) 049-16-4880 Months Hours Country) **Director** 85 Yrs 1 M 2 X March17,1927 Connecticut Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Micdical Exempler must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore tX Yes 2 ☐ No 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? Funeral 5164 Wright Avenue 21205 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any Injury or other treumatic event, In In Medical Examin 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes Give White Specify: 3 Widowed 4 ☐ Divorced Completed ear or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Office Clerk Social Security 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ George Wargo Margaret Fedor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Preston/daughter 1001 Hignet Way Baltimore MD 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MeadowridgeCemetery 5/26/12 Baltimore MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ PANCREATIC CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last ettending physiclen for use as the buris Physician/Medical The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 X No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) **Division of Vital** examiner?
1 Yes 2 No Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) HOSPICE မူ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending To the Hospital or Attendin within 24 hours after death. To the Funerel Director: Aft completely filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 06-2011

State

(Check

29b. Signature and title of certif

JACKIE JONES,

31. Date filed (Month, Day, Year)
NAY 2 4 2012

a.n

2300 DULANEY VALLEY RD.

ess of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Streeture

CRNP

3 🕱 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 May Wendell W. Wichmann 22 2:10 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lorien Mays Chapel Timonium Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1x2 M 2 □ F ne 18, North Dakota Director 502-10-1470 96 June **1**915 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehror any injury or other traumatic event, the Medical Experiments. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Baltimore Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Clynmalira Court 21131 **USA** 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Ares 2 No Black, White, etc. à 1 Never Married 2 Married If Yes, Give 1 Yes 2 No Specify: Specify. Completed 3 Divorced 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Colonel U.S. Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ferdinand Wichmann Lillian Hershleb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathlyn A. Cathell / daughter 5 Clynmalira Court; Phoenix, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 XCremation 3 🗆 Removal from State Hilltop Service Corp. 5/23/2012 Towson, MD 4 ☐ Donation S ☐ Other (Specify) 1/2/9/1/9 21. Signature of F 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or comminations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only of Immediate Cause (Final Onset and Death h sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner signed by the attending physician and d be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed as a consequence of resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Finastructure after death.

e Funeral Director: After this certificate has lefuneral director, page 2 s autopsy performe 1 Tyes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 X No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 💢 Natural injury work? 5 Pending 2 No Investigation Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. and title of cert 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Elizabeth Washington 345 A M Physician/ Gertrude May 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Co. General Hospital Columbia Howard Co Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 217-38-2521 7. Age (In yrs. last birthday) **Funeral** Director 1 🗆 M 2 🔀 F 71 01/07/1941 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Director 1 ☐ Yes 2🛣 No MD Howard Co. Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò items 23a 9426 Farewell Rd. 21045 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status event, the Medical Examiner Armed Forces Black, White, etc. or 1 Never Married 2 Married Yes 2 No by Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: Black If Yes, Give "natural", 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within 72 is and Mental Hygiene. 7 is marked other than "n Flementary/Secondary (0-12) College (1-4 or 5+) Housekeeping Manager Hotel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evo John L. Washington Helen A. Snowden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Chaney B. Washington 9426 Farewell Rd., Columbia, MD 21045 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Premation 3 Removal from State on-site Crematory 5-16-12 Baltimore, MD 4 Donation 5 Other (Specify) Joseph Adress of Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, 21. Signature of Funeral Service Licenses PA MD21217 uch Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ endocarditis disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, is adding to infiline diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for each conscound of -transit and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Other (specify) Pregnant at time of death been signed by the a should be detached f 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 performed 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work?
1 Yes 2 No 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifier 29c. License number 2012 DOO 66 515 M.D May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDAR LANE.

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year

2

4 2012

Polumbia, NO

amend 17 per fh. 928 6-1-12 sm. Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 16554 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nicholas Month 5 Urban Physician/ 0640 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD UPPER CHESAPEAKE BEL AIR . Social Security Number 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Hours (Month, Day, Year) Months Director 88 216-16-1345 1 X M 2 🗆 F MARYLAND 10-23-1923 Usual Residence of Deced 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director must be notified 1 🗌 Yes 2 😿 No KINGSVILLE MD. BALTO. 10g. Citizen of What Country? o 10e. Street and Number 10f. Zip Code 23a USA 21087 2903 BROCKTON DRIVE items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status rmed Forces
Yes 2 Black White etc. ō þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 WHITE If Yes, Give Year or Dates. 1943–1945 1 ☐ Yes 2 X No Specify. "natural" 3 XWidowed 4 ☐ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the OWN BUSINESS 8TH CONTRACTOR Be 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANNA E. BOEMMEL ANGELOS J. ZINK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 761 WINTERFIELD COURT BEL AIR, MD. 21015 BEVERLY CANATELLA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date TIMONIUM, MD. 5-25-2012 SCHIMUNEK FUNERAL HOME, INC. Signature of Funeral Service Licensee 22. Name and Address of Facility 9705 BELAIR ROAD NOTTINGHAM, MD., 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Carebrovasculer Accident Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) 6 months **Examiner** ancreadic Cancer Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and -tran that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death the 9 \ Unknown signed by t d be detach P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate | 1 Yes 2 No _ Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No ျပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Director: / Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 2012 Steven Foundain, MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Chesaprake Dr. Bel Arr, MD 21014 MO Steven Fountain

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mac Physician/ Lucy Maye Arrendell Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Lanham Doctor's Community Hospital If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 577-22-2362 **Director** 1 □ M 2 🗶 F 95 05/17/1916 NC Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🏹 Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 1617 Webster Street NW 20011 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: If Yes Give Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) LPN Howard University and Mental Hygier is marked other 1 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ 2 should be Callie Stallings Henry L. Wilder other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 any injury or other traumonce. 2215 Bunkerhill Rd. NE Washington, DC 20018 Amanda Sargent/Friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Fort Lincoln Cemetery 05/16/2012 Brentwood, MD 21. Sinnaure of Funeral Service Live see 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ menta disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-trar and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be P.O. Box 68760 the 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Ď in the past 12 months? Month Day Pregnant at time of death been signed by the a should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No has page 2 within 24 hours after death.

To the Funeral Director: After this certificate I To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Could not be filled in by the Accident 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DK. DANIEL ALEXANDER 12700 Godloes Romise Dr.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death $May^{Month} 2, 2012$ Physician/ 1:50 Ам David Albright Dayton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Braddock Heights Vindobona Nursing Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 224-28-4887 West Virginia Director 89 1 X M 2 - F April 9, 1923 Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Braddock Heights Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21714 United States 6012 Jefferson Boulevard 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 🔀 Widowed 4 🗌 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Crane Operator Steel Making Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jacob C. Albright Hanna C. Strawderman 1 and 2 should b of Health and Mei item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3008 E. Boss Arnold Rd., Jefferson, MD 21755 Peggy Kauffman / Daughter 20b. Place of Disposition (Name of cemetery crematory or other place)
Restnayen 20c. Location - City or Town, State 20a. Method of Disposition Date Page 1 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State May 5, 2012 Frederick, Maryland 4 Donation 5 Other (Specify) Memorial Gardens 21. Signal and eral Sovice Licensee Skkot Cody P.A. Restriated Fufferal Services, Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final disease or indition resulting in death)

Atherosclerosis of Coronary Artery Approximate Interval Between Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, Examine Due to or as a consequence of cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performe has death?
1 Yes 2 No 1 ☐ Yes 2 🛣 No After this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4XX Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 2 🗌 No 1 Yes s after death 2 Accident Investigation filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cortfying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 3, 2012 D 47951

State Registrar 814 Toll Haouse Ave., Frederick, MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Kazmi

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Sibte A. Ka
31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 16557 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Malyonth Farhad Arshadi 12, Day 2019ar 11:57P. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Montgomery Examiner 4b. City, Town, or Location of Death Suburban Hospital Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Davs Hours Min April ^{Day}, 1951 IRAN IRAN 216-78-2838 1 🛛 M 2 □ F Director 61 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Montgomery Boyds 1 Yes 2 No 10f. Zip Code 0 Citizen of What Country? 23a United States Funeral 20841 14301 Kings Crossing Blvd., #407 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 05-12-12 AT 1137 PM or i Black, White, etc 1X Never Married 2 Married þ 1 Yes 1 If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced "natural" Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Secondary (0-12) Salesman retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ghamar T. Arshadi Mohammad Arshadi 19a. Informant's Name/Relationship (Type, Print) Lydia Arshadi -daughter 196, Mailing Address (Street and Number or Rural Bouts Number, City or Town, State, Zip Gode) 20841 14301 Kings Crossing Blvd., #407 Boyds, MD 20841 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Parklawn Cemetery 5/16/2012 Rockville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Bornald Wors Borgwardt Funeral Home, PA MI 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician. Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of) Lung Cancer that initiated events Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical attending (IE FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year ed by the a detached f 1 L Yes 2 L g Unknown q I IInknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed I page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Narcotic Dependency; Respiratory Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2【X】No 24a. Was an autopsy performed? Yes 2 XNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital: ျ 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred iniury 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 1 🙇 Certifying Physician: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse graphitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) 0 The 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. SH 8600 Old Georgetown Road Bethesda, Maryland 20814 Barry J. Levin, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

DHMH 17 Rev 06-2011

2 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 12:30 A M Jesus Araujo De May Humberto Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs. . Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Davs Hours Min 216-49-5436 Director 1 🗶 M 2 🗆 F 103 Vrs El Salvador Feb. 5,1909 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location Director Montgomery 1 Yes 2 X No Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19311 Moon Ridge Drive 20876 El Salvador Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14 Bace - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 White If Yes, Give Year or Dates. 1 🕅 Yes 2 □ No Specify: Salvadorian 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 is and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Agriculture Farmer n Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ည Casimiro Solano Dorotea Araujo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19311 Moon Ridge Drive, Germantown, MD 20876 Maria Mirtala Mejia (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) ay 4, 2012 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All Souls Cemetery Germantown, MD 22. Name and Address of Facility
DeVol Funeral Home, 10 East Deer Park Drive,
Gaithersburg, MD 20877 21. Signature of Funeral Service Dicenses TRACU A) THEK M01117 . c 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 10 Immediate Cause (Final disease or condition Physician/ Kidhev hronic resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed prostatic hypertrophy 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a. Was an autopsy performed? Yes 2 X certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 SNo ည 1 KInpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred injury 5 Pending 1 Natural Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Humberto Division of Vital Records, Aravio, To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After

29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064502 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Center Drive Rockville Carpenter Brian 9901 Medical 31. Date filed (Month, Day,

State Registrar 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene 2 1 5 5 9 1- State Registrar Certificate of Death Reg. No.
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
	Physici		EDWARD CHARLES BUTLER May 2012 1:27a M
	/Medio Examir Funeral		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4d. County o
24698	Director		263-29-2688 X Yrs. JANUARY 30,1958 FLORIDA Usual Residence of Decedent
75	yland		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
0	a-f st	ctor	MARYLAND CHARLES WHITE PLAINS
H.	th with the Marylan 23a or 28a-f show	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
5	e 23a	rai	3305 PRINCE EDWARD DRIVE 20695 UNITED STATES 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-
2	Z IZ IS-UUSO d within 72 hours after death with the Maryland giene. er than "neturel", or freme 23a or 28a-f show in Medical Exprimermative rotified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes, Specify: BLACK
C	72 hours naturel',	etec	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working
3	within 906.	Completed	Elementary/Secondary (0-12) 1 YEAR College (1-4or 5+) WARRANTY SUPERINTENDENT RESIDENTIAL HOME BUILDER
3;	filed Hygir other		17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
0	re, Maryland ZIZID-u s 1 and 2 should be filed within 72 h Health and Mental Hygiene. Item 27 Ie marked other than "natu other traumatic event, the Wadical	To Be	CURTIS LAMAR BUTLER OZELLA MITCHELL BUTLER
Ш	Mary 12 shoul h and M 7 le mari traumati	ľ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20695
	and and sealth m 27		PATRICIA A. BUTLER / WIFE 3305 PRINCE EDWARD DRIVE, WHITE PLAINS, MARYLAND 20a Method of Disposition (Name of Date 20c. Location - City or Town, State
P	iges 1 or of or of		1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
士:	antimore mit. Pages 1: partment of He portant: If Iten y Injury or oth		4 Donation 5 Other (Specify) MARYLAND NAT'L MEM. PARK MAY 17, 2012 LAUREL, MARYLAND 21. Signature of Euneral Service Licenses 1 2 2. Name and Address of Facility
	beartimore, Me permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other traugung.		THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) A Pulmontic Immediate Cause (Final disease or condition a Pulmontic Immediate (Final disease or condition a
	Examiner		Due to (or as a consequence of):
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):
	cuted nd ransit	Examiner	Cause (Disease of injury that initiated events c.
9	bu, be executed incian and burial-transit		resulting in death) Last Due to (or as a consequence of):
1	cate ohys	dical	d
(BOX 6	0	IF FEMALE: 23b. Was decaded graphs. 23c. If yes, outcome of pregnancy 23d. Date of delivery
٤	Atlanding Physician: The law requires that the death certific death. cleath. ctor: After this certificate has been signed by the attending to the funeral director, page 2 should be detached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No
	that the death	hysi	9 Unknown 9 Unknown
	S, T	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
	w require		1 Yes 2 No 3 Probably 4 Unknown
	e lawr has be	Completed	24a. Was an autopsy findings available prior to completion of cause of
-	The The cate by page	Con	performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
	VIII sician certifi rector	Be	25. Was case referred to medical examiner? Hospital: Hospital:
, y	DIVISION OT I or Attending Physicater death. Director: After this in by the funeral di	To To	27. Manper of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
a.	nding ath. r: Afte	Certification:	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 5 /4 20(2 M 1 Yes 2 No
# .	VIS	tifica	3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 4 See Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)
i	Ital or rall Dig Tal Dig	Cer	
	DIVISION OT VIXAI HE To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To ti withii To ti comp	Σ	29b. Signature and title of certifier Nappleon Magpantay ND 29c. License number Fn 2007 513 29d. Date signed (Month, Day, Year) 05/07/2012
	20,5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	By		Napuleon Magantay MD, S Garrett Ave La Plata MD 20646
	St Regist	ate	31. Dale filed (Month, Day, Year) 32. Hegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 16560 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6 Day Physician/ MAY Month 20°12 BRASWELL 1900 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 31, 1915 Funeral Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 M 2 X F Days Hours Country) **Director** 96 NC 577-60-3553 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Rockville MD Montgomery 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? pe Funeral 23a must ! USA 1235 Potomac Valley Rd. 20850 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ral", or iter Examiner 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married within 72 hours after 5-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Year or Dates Black traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 Elementary/Seconday (0-12) 9th College (1-4 or 5+) Dept. of Justice Elevator Operator 2 Be land filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental f ပ္ Maggie Parks Leonard Bell Mary should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Bryans Road, MD 20616 5256 Greenville Dr. James Hackett-Cousin or other Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location ~ City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Brentwood, MD Lincoln Cemetery 5/17/2012 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee Marshall-March Funeral Home of Maryland Victoria Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Qnset and Death** Preumonia Physician disease or condition Week Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) sician and burial-transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month ed by the 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has autonsy performed?

1 Yes 2 No death? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🛛 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur 2 29d. Date signed (Month, Day, Year) D38262

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Registrar

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Shady Grove

Gathersburg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mendhiratla

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $20 \ 1 \ 2$

16561

			For State Registrar		State of Ma	aryiano	-	tificate				nentai m			_	100	0 1
			Decedent's Name	(First, Middle, Las	it)				0. 2			2. Date of D			T	3. Time of Dea	th
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W. A.			Holy Cro	ss Hospi				Silv				T		iontgome			
	Funeral Director		577-42-2		ox		st birthday)	If Under Months	Days	Hours		8. Date of Bi (Month, D		9. E	irthpla Co <i>untry</i>	ce (State or For)	reign
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Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status1 X Never Marrie3 □ Widowed 4		Armed Forces? 1 Yes 2 II If Yes, Give Year or Dates.	No	If	/as Decede Yes, specif	y Cuban	, Mexic	an, Puerto	ecify Yes or No Rican, etc.)) -	14. Race - Am Black, Wh Specify: B1	ite, etc		
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2	Physician .	107	Immediate Cause (F	inal	Sepsis											nset and Death	
	Medical Examiner		resulting in death)		Due to (or as a	conseque	ence of):										
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<u> </u>	al or s afte		4 Ly Hollinoide	determined	building, etc.	(Specify)					Į.	City or To				,	
	to the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director,	ledical	29a. Certifier 1	Xertifying Phys	ician: To the best of n	ny knowle	dge, death or	curred at the	ne time,	date an	nd place, a	nd due to the c	ause(s)	and manner as s	stated.		
	the H nin 24 the Fi	Me	only one) 3 l	□ Certifying Nurs	ner: On the basis of exe e Practitioner: To the	best of my	knowledge, o	death occurr	ed at the	time, c	ate and pla	the time, date ice, and due to	the caus	e, and due to the se(s) and manner	as stat	(s) and manner s ed.	stated.
			29b. Signature and ti	tle of certifier					icense r					ate signed (Mon	th, Day	, Year)	
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16562 Certificate of Death Reg. No. , Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MA 12:05AM Louis K. Barton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DOCTOR'S COMMUNITY HOSPITAL LANHAM PRINCE GEORGE'S 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min WASHINGTON, DC Director 579-09-6332 1**X**□ M 2 □ F 92 10-16-1919 Usual Residence of Decedent show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 1 😾 Yes 2 🗌 No 28a-f MD PRINCE GEORGE'S CAPITAL HEIGHTS 10e. Street and Number 10g. Citizen of What Country? must be 23a Funeral 126 - 68TH PLACE 20743 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black White, etc. ō þ ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates. NO 1 ☐ Yes 2 ☐ No Specify. Specify: Widowed 4 ☐ Divorced "natural" Completed BLACK or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) 12TH GRADE College (1-4 or 5+) TRUCK DRIVER DC GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) r and Mental I ပ ALBERT BARTON ELSIE CARTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 LOIS F. SEXTON-MERKERSON 126 - 68TH PLACE CAPITAL HEIGHTS, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State LINCOLN MEMO. CEMETERY 5-19-2012 SUITLAND. MD ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee #CC0203 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. 524 - 8TH STREET, N. E. WASH., DC 20002-5236 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying as a consequence of g physician and as the burial-transit Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No detached for Day Year Pregnant at time of death 9 Unknown Unknown or Attending Physician: The law requires that the after death. P.O. β Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I 1 ☐ Yes 2 ☐ No 1 Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 1 Yes 2 No ဂ 1 Inpatient ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer (Month, Day, Year) injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 06-2011

Registrar

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Carham, M.D. 20706

completed cause of death (Item 23a) (Type, Print)

MDO

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 16563 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:20 PM Helen A. Brooke mau 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** De Harford Harre Grace tizens Nursing Home If Under 24 Hrs. If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** 1070471922 1 🗆 M 2 🕱 F Days Hours Min. Country) Director 534-20-7960 89 Iowa Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location filed within 72 hours after death with the Maryland Director Yes 2 🗌 No Havre de Grace Harford MD 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21078 332 Pintail Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give 3 ➡ Widowed 4 □ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important; If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker 12 Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Maude Arnold Dallas Mathews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr., Havre de Grace, MD 21078 Pintail Donald Brooke (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date any injury or conce. 1
Burial 2
Cremation 3
Removal from State Ferris & CoInc.05/14/2012 West Chester, PA 4 Donation 5 Other (Specify) RA. Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. S.Washington St.Havre de Grace, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final and jour mathy Physician disease or condition Medical resulting in death) Due to (or as a contequ Examiner mm aut Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Petal death Pregnant at time of death Month Day Year signed by the a d be detached f 9 Unknown Division of Vital Records, P.O. II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes within 24 hours after death.

To the Funeral Director, After this certificate has been si completed filled in by the funeral director, page 2 should Brooke, Helen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 🗹 No 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Man er of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending Natural 5 Pending work? 1 ☐ Yes 2 ☐ No М Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ٥ 14 MY 41M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 160 K Mn 4 Wb egistrar's Signatu State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 16564 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Physician/ ELIZABETH A. BARROW 2:15 A M 1, 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT WILLIAM HILL MANOR EASTON If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min JULY 13, 75 1936 MARYLAND Director 220-32-2441 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 501 DUTCHMANS LANE 21601 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examirane. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 PRIVATE RESIDENCE HOUSEKEEPER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ISAAC PARROTT LILLIAN ARRINGTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HENRY L. BARROW, III, SON 8635 BRENTON DRIVE, EASTON, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 D Burial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 5/4/2012 STEVENSVILLE, MD FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON STREET, EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that days dithe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw shock, or heart failure. List only one cause on Immediate Cause (Final nset and Death STAGE EMPHYSEMA Physicann/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a conse wence of cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death.
Funeral Director; After this certificate has been signed by the attending physicis P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No 4 Pregnant 9 Unknown Day Year Pregnant at time of death signed by the all id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ATRIAL FIBRILLATION, CONGESTIVE HEART FAILURE Records. 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No RENAL IUSUFFICIENCY, PULMONARY HYPSETENSION 24a. Was an page 2 s autopsy perform Yes 2 No Division of Vital 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) <u>1</u>0 Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred iniury 1 X Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Medical 🜠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the 1 within 2 To the I only one

State Registrar

MAY 03 2012

death (Item 23a) (Type, Print)

00053074

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Day Month May Physician/ 2012 ear 3:30 Russell Evans Bond, 6, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring P.G. Renaissance Gardens at Riderwood Village 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Director 141-22-8691 1 XX/1 2 | F 83 9, 1928 NJ May Usual Residence of Decedent 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Prince George's MD Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3158 Gracefield Road, #205 20904 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Specify: White 1 X Yes 2 No
If Yes, Give Korean
Year or Dates Conflict 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 M No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Attorney Law event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic even 2 , Ma.,
, 1 and 2 should be
ant of Health and M
ant: If item 27 is r Russell Evans Bond, Sr. Elizabeth Abigail Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie M. Bond/Wife 3158 Gracefield Rd., #205, Silver Spring, MD 20904 Date 9 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, May Burkittsville Cemetery 4 Donation 5 Other (Specify) Burkittsville, MD 2012 21. Signature of Funeral Service Francis J. Collins Funeral Home Inc. Wekard 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death yrs Immediate Cause (Final 20 Physician/ Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Atrial Fibrillation 10 yrs Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) -transit Congestive Heart Failure 3 y<u>rs</u> and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) signed by the ail 1 Yes 2 L 9 Unknown Unknown P.0. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebrovascular Arteriosclerotic Disease, Dysphagia Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 tal or Attending Physician: The lav rs after death. al Director: After this certificate has led in by the funeral director, page 2 performed? 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 👿 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) Hospital: 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending work' 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 XCertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

Registrar

5+1

31. Date filed (Month, Day, Year) MAY 08 2012

e and address of person

Eileen Gemmell,

only one)

29b. Signature and title of certific

3110

completed cause of

58/de 1

m 23a)(Type, Print) Gracefield Road, Silver Spring, MD 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	larylan	-	artment of rtificate of		d Mental F	Reg. No	7111	2 1656															
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, L Mumtaz 4a. Facility Name (If not institution, g 4505 Adrian	ive street and number		gum		or Location of E		2012	c. County of Dea																
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	the Marylan 28a-f show notified at	rector	Md. 10b. County Md. Montg	omery	10c. City	Rock	ville			10g. C	itizen of What C	10d. Inside City Limi 1 Yes 2 N															
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other then "neturel", or Items 23s or 28s-1 show other traumatic event, the Medical Examinational De notified at	by Funeral Director	4505 Adrian 11. Marital Status 1 Never Married 2 Married 3 Note: Widowed 4 Divorced	12. Was Deceder Armed Forces	? } \0	1	208 Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ € Was	Hispanic Origin ban, Mexican, P	? (Specify Yes or Puerto Rican, etc.)		S A 14. Race - Ame Black, Whi	te, etc.															
Maryland 21215-0036	filed within 72 hou Hygiene other then "neture ent, tre Medical E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 1 2	rade completed) College (1-4o	5+)	(Give life.	dent's Usual Occi kind of work don DO NOT use retir emaker	e during most of ed)			Home	/Industry															
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	s 1 and 2 sho f Health and item 27 Is my other traum		Hamid Rabbani 20a. Method of Disposition	- Son	20b. P	450		n St,	Rockvil Date	1e,M		853	_														
Baltimore,	permit. Pages Department of I Importent: If it any injury or o		1 ☑ Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Special Service Lice) 21. Signature of Funeral Service Lice	cify)	B 1	. Nat	Ceme Name and Add	t. 5	-7-12 411ken	nedy	st,n.	1d. w. .C. 2001:	1														
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition			n. Do not en	er the mode of dy	ing, such as ca	rdiac or respirator	ry arrest,		Approximate Interval Between Onset and Death															
	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or a	s a consequ	uence of):	emen	tier	n Mell																		
,092	ate be executed hysician and the burial transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a			Diabe	etes	Mell	itu	5																
.O. Box 687	The law requires that the death certificate ate has been signed by the attending phy.															Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	Ideath 3[⊒Ectopic pregnan ⊒ Other <i>(specify)</i>	су		il	23d. Date of de Month	elivery Day Year	
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	To the Hospitel or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical (29a. Certifier 1 Certifying (Check only one)	Physician: To the bes aminer: On the basis and manner	of examina	wledge, deat tion and/or in	vestigation, in my	opinion, death	place, and due to occurred at the til	me, date at	nd place, and du	e to the cause(s)															
)	To t To t	×	29b. Signature and title of certifier Cecha	w sho	reed	W	DO	OY3Y		4	ate si ned (Mor	12															
			30. Name and address of person when the same address of pe	A. Wha	lid,	4D.		ferra	va Ave	wh	enter	MD 2090)ر														
	Sta Registi		31. Date filed (<i>Month, Day, Year</i>) MAY 0 9 20		trar's Signa	fura for	del																				

12-03698	
Mark Wayne Brady	

2-03698		Please Type or Print in Black I		-	_	jible.	
lark Wayne Br	ady	State of Maryland / Dep			Hygiene	201	2 1656
		Registrar	ertificate of D	Death		g. No.	
Physici ledical Exami		1. Decedent's Name (First, Middle,Last)			2. Date of Death Month	Day Year	3. Time of Death 1652 hrs
neulcai Exaiiii	nei	Mark Wayne Brady 4a. Facility Name (if not institution, give street and number)	I 4h	City, Town, or Location of Dea	May 14, 20	112 4c. County of Death	1002 1119
		627 Ridgely Avenue Apt. 2		Annapolis		Anne Arundel	
Funeral		Social Security Number 6. Sex 7. Age (In yrs.)	last birthday)	If Under 1 Year If Under 24H	rs. 8. Date of Birtl	h(MM/DD/YYYY) 9. Birt	hplace (State or
Director		143-64-6294 1XM 2□F 45	-	Months Days Hours M	n. 11/04	/1066 Cou	Camden New Jersey
		Usual Residence of Decedent			11/04	71300	Jersey
, any		10a. State 10b. County 10c. City	y, Town or Location				10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ō	Maryland Anne Arundel	Annap	olis			1 XX Yes 2 No
Maryl 28a-1 d at o	Director	10e. Street and Number	1	Of. Zip Code	10	g. Citizen of What Cour	ntry?
ith the Maryland 23a or 28a-f sho notified at once.		627 Ridgely Avenue Apt. 2		21401		United Stat	es
h with	eral	11. Marital Status 1 Never Married 2 Married Armed Forces?		Decedent of Hispanic Origin? (14. Race - Americ White, etc.	can Indian, 8lack,
or it	Fun	1 Yes 2 X No			, ,	171	nite
s afte	ģ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)		es 2^{\sum} No specify: Usual Occupation (Give kind o	work done	Specify: WT	
nath	ted	Elementary/Secondary (0-12) College (1-4 or 5+)		of working life. DO NOT use re		TOD. TATIC OF BUSINESSAI	radati y
36 hin 7. than edical	ompleted	10	Pinsett	er Mechanic		Machinery	Mechanics
5-00 ed wit sygien other	Con	17. Fathers Name (First, Miodle, Last)		18.Mother's Nan	ne (First, Middle, M	laiden Surname)	
21215-0036 uld be filed within 72 h Mental Hygiene. marked other than "n c event, the Medical E.	Be	Charles Brady		Annett	e Cline		
21 hould hould Me	2	19a. Informant's Name/Relationship (Type, Print) Kenneth Brady / Brother		ddress (Street and Number of	Rural Route Numi		Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumantic event, the Medical Examiner must be notified at once		• •		ennsylvania Av nd. New Jersey		C 14	T 01-1-
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Baltimore, permit. Pages I ar Department of He Important: If ite injury or other tr		21. Signature of Foreral Service Licensee		ne and Address of Facility CI South Main Str			
		23a Part I. Enter the disease, or complications that caused the death					Approximate Interval
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	ner	if any, leading to immediate cause. Enter Underlying Cause	of):				
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Box 68760, e death certificate be the attending physic of for use as the bur	an/Medi	IF FEMALE: 23b. Was decedent pregnant in the	gnancy			23d. Date of delivery	
68 certifi nding se as	ian	past 12 months?	2 Fetal		nancy	Month D	ay Year
Box 6 e death cer the attendied for use	Physici	1 Yes 2 No 9 Unknown 9 Unknown	5 Other	(Specify)			
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1 of ling Ph After th funeral	n: T	27. Manner of Death 28a. Date of Injury	28b. Time of Injur	y 28c. Injury at Work?	28d. Describe he	ow injury occurred	
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Division of Vital Records, pital or Attending Physician: The Jaw requirems after death. eral Director: After this certificate has been sifilled in by the funeral director, page 2 should the funeral director, page 2 should	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At h	nome, farm, street, f	actory, office building, etc.	28f. Location (St or Town, St	treet and Number or Rur ate)	al Route Number, City
Spital hours neral / fillec		4 Homicide determined (Specify) 29a. Certifier Certifier Physicles: To the best of my knowled					
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	edical	Check only one) 2 Medical Examiner: On the basis of examination :	-				
To t With To t	Med	and manner stated. 29b. Signature and title of certifier		29c. License number	I	29d. Date signed (Mon	
		Annot And thank and		O.C.M.E.		May 15, 2012	
		30. Name and address of person who completed cause of death (Iter	m 23a)				
		Pamela E. Southall, MD Assistant Medical Exa	·	V. Baltimore Street, Bal	timore, MD 21	223	
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signat	tare				
Regis	trar	MAY 2 4 2012 Benefit B. A					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Items 23aft1,11,27 per me,g927,05/23/2012dhb Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 22 2012 9:19 Рм John William Bushman Jr 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 213-29-3879 Davs 22 1 **X** M 2 □ F March 1, 1990 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Thurmont 1 🗌 Yes 2 🏻 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 13035 B. Brice Road 21788 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married ☐ Yes 2 K No If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Food Service cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Loretta Shriner John Bushman, Sr. 19a. Informant's Name/Relationship (Type, Print) . 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 13035 B. Brice Road, Thurmont, Maryland 21788 Loretta Morris - Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4-30-2012 Blue Ridge Cemetery Thurmont, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Sig Mure of Funeral Service Licensee lue 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between Onset and Death Immediate Cause (Final cherholobally disease or condition resulting in death) Due to (or as a consequence of): Chronic Alcohol Abuse complicating Sequentially list conditions, Dilated Cardiomyopathy if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Que to (or as a cons uence of): Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 No Unknown 9 Unknown

Physician. Medical **Examiner**

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To the Hospital o within 24 hours af To the Funeral Di

director

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Certificate:

Medical

29a. Certifier

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

any in

Physician/

Medical

Examiner

Funeral

Director

28a-f show

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23a

items 2 death

and Mental Hygiene.

permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve

72 hours after

Baltimore, Maryland 21215-0036

must be notified at

Examiner han "natural", or it e Medical Examine

the

Funeral

Examine Physician/Medical ò Completed

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

790-10	1 L Yes 2 L
	24a. Was an autopsy performed 1 ☐ Yes 22 No
al	GC Diago of Dooth (Chook palu page)

25. Was case referred to medic 1X Yes 2 □ No 27. Manner of Death

5 Pending Accident Investigation Suicide 6 Could not be 4 Homicide

Hospital

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

death?

24b. Were autopsy findings available prior to completion of cause of

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Marchs

729

Other:

Frederick

29d. Date signed (Month, Day, Year) 412212012

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Marines Nu

Day, Year) Date filed (Month)

Registrar's Sign

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Physician/ Camper Eleanora Addie May 2012 2:00 PΜ Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Genesis HealthCare -The Pines Easton Talbot 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💆 F Months Hours Min. 07-16-1913 Maryland 217-16-9619 Director 98 Usual Residence of Decedent or 28a-f show 10h County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland must be notified at Director Md. Talbot 1 X Yes 2 No Easton 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral items 23a 117 S. Hanson Street 21601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 14 Race - American Indian 11. Marital Status traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 0 Completed by 1 Never Married 2 Married Addie Camper Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: Specify: Black 3 Widowed 4 Divorced "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me life, DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Self - employed Seamstress 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Page 1 and 2 should be William Henson Camper Dennis Leah Jane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 41223, Arlington, Va. Sheryl Camper/Grand Daug. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 05-12-12 Easton, Maryland Richard Mem.Park 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bennie Smith Funeral Home 21. Signature of Funeral Service Licenses 426 Dover Street, Easton, Md. 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Failure disease or condition resulting in death) Medical Examiner demen Bequentially list so iditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy page 2 this certificate 1 🗆 Yes 2 🖸 1 Yes 2 CNo 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 10 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Certificate: work? 1 ☐ Yes 2 ☐ No Natural injury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State, 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Meditifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) Signature and title of certifie

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31. Date filed (Month, Day, Year,

MAY 0 9 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

3:17 pm

Montgomery

Pennsylvania

U.S.A.

White

Onset and Death Months

Day

2 No

29d. Date signed (Month, Day, Year)

May 07. 2012

Year

Assisted

10d. Inside City Limits

1 Yes 2 1 No

9. Birthplace (State or Foreign

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Edward T. Cullen, M.D., 7625 Wisconsin Ave., Suite 101, Bethesda, Maryland 20814

7 Gellas d

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0026607

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 April Physician/ 5:40 P. M Norman Marvin Carmen 30, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Collingswood Nursing and Rehabilitation Center Rockville Montgomery 5. Social Security Number 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Month, Day, Yea C. 31, New York 052-20-2743 84 Director 1 🗶 M 2 🗆 F 1927 Dec. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director MD Prince Georges Beltsville ¹X Yes 2 ☐ No 10f. Zip Code ō 10e. Street and Numbe 10g. Citizen of What Country? Funeral 4101 Powder Mill Road 23a 20705 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Medical Examiner was become Ever in S.S.

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Was become in Ever in S.S.

Was become in Ever in S.S. Black, White, etc. ō ģ 1 Never Married 2 Married 1 X Yes 2 □ No WW II If Yes, Give**Korean War** Year or Dates. Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural" Completed 3 XWidowed 4 Divorced 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Hearth and Mental Hygiene. Important. If item 27 is marked other than any injury or other traumatic event, the Me once. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Raphael Hyman Bertha Carmen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Murray/Daughter 4101 Powder Mill Road, Beltsville, MD 20705 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 1 2012 Georgetown University Medical Center ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 Donation 5 Other (Specify) Center 22. Name and Address of Facility Columbia Mortuary Services, P.A. Signatury of Funeral Service Li Mo /Moo969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. a e nui PMO disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a cons an and the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last buriatbeen signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 g Unknown 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 After this certificate has performe 2 🗆 No 1 Yes ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: Al 2 🗌 No the f Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signa D38262

Registrar

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State

31. Date filed (Month, Day, Year)

043

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Shady Grove Court Garthershu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Month Physician/ May 2:50 P Cuff V. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Kensington 2713 Calgary Avenue If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number Age (In yrs, last birthday) 8. Date of Birth Sex 1 ☑ M 2 ☐ F **Funeral** Months Days Hours Min. Jan. 10, 1952 Washington, DC **Director** 216-60-0969 60 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nature."
any injury or other traumatic executions. 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 X Yes 2 No Kensington Md Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 2713 Calgary Avenue 20895 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Yes, Give 1 ☐ Yes 2 🔀 No Specify Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Office College (1-4 or 5+) Elementary/Seconday (0-12) of Management & Budget Accountant Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ပ Robert Cuff, Sr. Ruth Wells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2713 Calgary Avenue, Kensington, Md. 20895 Margaret Z. Cuff/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 2012Gate of Heaven Cem. Silver Spring, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility DeVol Funeral Home MO1315 ben A Sell 2222 Wisconsin Ave., N.W. Washington, DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Metastatic Squamous Cell Cancer of Hypopharynx Phynician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying and Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown is been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed 1 ☐ Yes 2 ☐ No certificate Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 🗓 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) မ this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 10 May 7, 2012 D0066346 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Shanthi Marur, M.D.

31. Date filed (Month, Day, Year)

1650 Orleans St., Room G92, Baltimore, Maryland 21231

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Physician/ 2012 11:00A Mary Cecchini Rache1 May Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Charles Hughesville 6250 Nana Drive Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 081-30-5757 1 □ M 2 🗓 F 73 **Director** New York 08/10/1938 or 28a-f show notified at 10d Inside City Limits 10c. City, Town or Location 10b. County within 72 hours after death with the Maryland 10a. State Director 1 Yes 2 X No **Hughesville** Maryland Charles 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number must be r Funeral USA 20637 6250 Nana Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. "natural", or item edical Examiner n 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theresa Altimonte Gilbert F. Mancuso 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6250 Nana Drive, Hughesville, MD 20637 Louis R. Cecchini/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St.Mary's Cemetery 05/09/2012 Bryantown, MD Signa of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Conce Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) cause (Disease or injury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ atter in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day for Pregnant at time of death ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ûnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 autopsy perfor**med** Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Yes 2 No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? Certificate: After injury Natural 5 Pending n 24 hours atter usu... he Funeral Director: Aff 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Hospital Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 3 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier to completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 31. Date filed (Month, Day, Year) NAY 2 4 2012 32. Registrar's Sig State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Mav Month Physician/ 12 2012 11:12P. M Zoila Rosa Caceres Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Silver Spring Holy Cross Hospital . Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Aug. 31, 1926 1 M 2 TXF 85 218-96-3535 El Salvador Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Maryland Montgomery Silver Spring 1 🗆 Yes 2 🕇 No 10e, Street and Number 10f. Zip Code Citizen of What Country? Funeral 20906 United States 3347 Hewitt Avenue, #202 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 X Yes 2 □ No Spe**₩l Salvadoran** Specify: White Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Zoledad (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Vanegas -grandson 3347 Hewitt Avenue, #202 Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 5/16/2012 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer Bohald ViesBorgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 2hours Immediate Cause (Final Physician/ Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Atherosclerosis Sequentially list conditions, if any, leading to min solute cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Coronary Artery Disease years attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical certificate be P,O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 MNo
9 Unknown Hospital or Attending Physician: The law requires that the death been signed by the atte Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus; Renal Insufficiency 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 1 N has funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 K ER/Outpatient 3 I DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the f Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) May 14, 2012 D35055 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jose F. Bonelli, M.D. 8807 Colesville Road Silver Spring, Maryland 20910 31. Date filed (Month, Day, 32. Registra & Signat State

DHMH 17 Rev 7/2009

Registrar

MAY 2 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ABIN 3:14 M 2012 WHAMED 4a. Facility Name (if not institution, give street and number) Medical 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Ltimos mml 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) **Director** None 1 M 2 - F 74 4-4-1938 Guinea ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. Montgomery Silver Spring 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1106 Copley Lane 20904 Guinea death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes If Yes, Give and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates. 16b. Kind of Business/Industry Guinee 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Army Republique Captian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Aboubacar Diane Diaka Diane traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i Aboubacar Diane - son Copley La, Silver Spring, Md. 20904 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Page 1 cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland NatiOnal 5 - 8 - 12Laurel, Md. 4 Donation 5 Other (Specify) permit. f Funeral Service L 22. Name and Address of Facility 411kennedy st,n.w. Ru Universal Mortuary Inc, Wash, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 0515 disease or condition Medical resulting in death) Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury neumonia Due to (or se a conesquence of, The state of Abdominal and that initiated events Due to (or as a consequence of): resulting in death) Last physician s the buria Physician/Medical Multi Organ P.O. Box 68760 38 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) attending IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery j in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 2 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Kenal 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b page 2 performed? 1 Yes 2 No Yes 2- No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident filled in by the Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 19223 MD Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHIM JAM Greenzsi Baltimore Date filed (Month, Day, Year, Registrar's Signat State MAY 09

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ARNOLD ENGEL 3, Day MACY 2012 4:10A. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 071-30-9500 9. Birthplace (State or Foreign Days Hours Feb. 9,1932 New York, NY Director 80 1X M 2 □ F or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Calvert Prince Frederick 1 🗆 Yes 2 🐰 No the 10e. Street and Number 10f. Zip Code ō r items 23a or ner must be n 10g. Citizen of What Country? Funeral 313 Highland Terrace 20678 United States permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important; if item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 11. Marital Status 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 res, Give Year or Dates.1956-1960 1 ☐ Yes 2 ☐XNo Specify: White 3 Widowed 4X Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Physician Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kate Wishnossky Louis Engel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 Highland Terrace Prince Frederick, MD 20678 Edward M. Engel -son Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ivy Hill Cemetery 5/10/2012 Laurel, Maryland 4 Donation 5 Other (Specify) 21. Signature Funeral Pervice Licen Donald Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 28a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Physician/ Cerebrovascular bleed disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sarcoidosis Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: nse : 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Arthritis; Chronic Back Pain 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy • Hospital or Attending Physician: The 124 hours after death.
• Funeral Director; After this certificate hetely filled in by the funeral director, page performed? Yes 2 No 2 X No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No မ 1X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work ☐ Accident 1 Yes 2 No Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2

To the F

complet Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2+1 D53691 May 3, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajay Reddy, M.D. 3200 Tower Oaks Blvd. Rockville, Maryland 20852

State Registrar 31. Date filed (Month, Day, Year)

MAY 08 2012

2. Registrar's Signature

12-03539		Please Type	or Print in Bla	ack indelible i	nk. Ensu	re All Copi	es Are Le	gible.	201	2 1657
Joseph Kendall i		r, 3rd State I- For State Registrar Amended#17pe	of Maryland /	Department of	Health ar	nd Mental F	lygiene	eg. No.		
Physicia	ın/	Registrar AMENGEO#1/De 1. Decedent's Name (First, Middle, La	erruneraino st)	me5/71/12cc	doh/ha_	<u></u>	2. Date of Dea Month	ith	Vans	3. Time of Death
Medical Exami	ner	Joseph Kendall	Fryer, 3rd				May 7, 20	12	Year	1500 hrs
		4a. Facility Name (if not institution, gi 10595 Pleasant View Pla			tb. City, Town, o Newburgh	or Location of Deal	h	4c. Cour Charl	nty of Death es	
Funeral		Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday)	If Under 1 Ye			rth(MM/DD/Y	9. Birt	thplace (State or
Director	- 1	218-92-7280	χM 2□F 4.9) Yrs	Months Da	ys Hours Mi	n. 09-27.	-1962	Cor	Washington
		Usual Residence of Decedent								404 1-14-04-1-14
w any		10a. State 10b. County		10c. City, Town or Locati	on					10d. Inside City Limits 1 Yes 2 X No
Maryland 28a-f show	ē	Maryland Charle:	s	Newburg	10f. Zip Code			log. Citizen of	What Cou	
r 28s	Director							=		
ith the	읥	10595 Pleasant V	iew Place	Everin II S I 12 We	20664	lispanic Origin? (§	Specify Ves or No		ed Sta	ates can Indian, Black,
ath w	by Funeral	1 Never Married 2 Marrie	d Armed Forces?	If Y	es, specify Cuba	an, Mexican, Puert	o Rican, etc.)	, w	/hite, etc.	our main, since,
", or	린	3 Widowed 4 X Divorce	d If Yes, Give Year	∑ No 1 □	Yes 2 X N	o specify:		Speci	∜: Whi	ite
ours ad		15. Decedent's Education (Specify of	or Dates:			ation (Give kind of		16b. Kind of	Business/I	ndustry
72 h	용	Elementary/Secondary (0-12)	College (1-4 or 5	i+)	DSCOI WORKING III	e. DO NOT use te	шөау			
903 within iene.	Completed	9		Stee	el_Erect	OT 18.Mother's Nam	a (First Middle	Cons	struct	ion
filed if Hyg		17. Father's Name (First, Middle, Las Fryer							me)	
212 ald be Menta mark	To Be	Joseph K. Fyer, 19a. Informant's Name/Relationship (19b. Mailing	Address (Stre	Karen eet and Number or	L. Mell Rural Route Nur	perg mber, City or 1	Town, State	, Zip Code)
AD 2 shot 1 and 27 is 1		Joseph K. Fryer.	TV/Son	103	West Ha	wthorne	Dr. La	Plata.	MD 20	0646
e, N I and Health item	1	Joseph K. Fryer,		20b. Place of Dispos	ition (Name of c		Date			Town, State
nor in the		1 X Burial 2 Cremation 3 4 Donation 5 Other Specif		Trinity Me		05-	14-2012	Walde	orf. N	Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f shu injury nr nther traumante event, the Medical Examiner must be notified at once.	ı	21. Signature of Funeral Service Lice		22. N	lame and Addre					al Home, P.A
E E E		Davil (Echos	MC	00945 2.	11 St. N	Mary's Av	e. La P	lata, l	<u>laryla</u>	and 20646
Physician Medicul		23a. Part I. Enter the disease, or comfailure. List only one cause on e	each line.		ne mode of dyin	g, such as cardiac	or respiratory an	rest, shock, or	heart	Approximate Interval Between Onset and
Examiner	l	Immediate Cause (Final disease or condition resulting in death)		Wound of Chest						Death
			Due to (or as a conse	quence of):						
	힐	if any, leading to immediate	Due to (or as a conse	quence of):						
	xaminer	(Disease or injury that initiated	Due to (or as a conse	guanco of):			- 			1
ited d ansit	-ш	events resulting in death) Last	·	querice ory.						
executed an and al - transi	Physician/Medical	UNPENDED	AMENDED							
760, ficate be exe g physician :	Med	IF FEMALE:	23c. If yes, outcom	ne of pregnancy				23d. Date	e of delivery	,
OX 687 eath certific : attending f	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at t	time of death	tal death 3	Ectopic pregr	nancy	Mont	ո [Day Year
Box 68760. e death certificate b the attending physical for use as the bu	sic	1 Yes 2 No 9 Unknow	T D	time of death 5 Ot	her (Specify)					
D. B. t the de by the ached f		Part il. Other significant conditions	contributing to death	but not resulting in the u	inderlying cause	given in Part I.	23e. Did t	obacco use co	ontribute to	the cause of death?
b, P.O. ires that the signed by I be detach	db						1 Ye	s 2 🗸 No	3 Prob	pably 4 Unknown
ords, w requir s been s should	Completed						24a. Was auto			topsy findings available completion of cause of
e law e has ge 2 sl	ā							ormed?	death?	
tal Rec		25. Was case referred to medical			26.Pla	ce of Death (Chec		2 110		2
Vital I hysician: this certifi ul director,	o Be	examiner? 1 ✔ Yes 2 No	Hospital: 1 Inpatier	nt 2 ER/Outpatient	3 DOA	Other Nurs	ing Home 5	Residence	6 🗸 Other	: Scene
1 Of Jing Ph.	n: To	27. Manner of Death	28a. Date of Injur	ry 28b. Time of I	njury 28c. In	jury at Work?	28d. Describe Subject sho		curred	
ion tendii tor: /	atie	1 Natural 5 Pending 2 Accident Investiga	May 7 2012	FOUND: 1355 hrs	1_	Yes 2 ✓ No	oubject site	J. 30.11		
Division of Vital Records, P.O. pinal ar Artending Physician: The law requires that the ours after death. eral Director. After this certificate has been signed by filled in by the finneral director, page 2 should be detach	Certification:	3 ✓ Suicide 6 Could no	t be 28e. Place of Inj	ury - At home, farm, stree	et, factory, office	building, etc.	or Town,	State)		ral Route Number, City
Di (ospital I hours a uneral I ly filled	Cer	4 Homicide determin	1-7-1-77 1103				10595 Please	ant View Pla		
Division of Vital Records, P.O. Box 68760, To the Hospital tr Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	edical		er:On the basis of exan	/ knowledge, death occur nination and/or investigat						
To With	Med	29b. Signature and title of certifier	and manner stated		29c. Licer	nse number		29d. Date s	igned (Mo	nth, Day, Year)
		CALDO L	000000		0.0	C.M.E.		May 8, 2	2012	

00/15

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan MD Assistant Medical Examiner 900 V

Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State 31. Date filed (Month, Per, Year), 2012

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ 2012 Robert Charles Flogaus РМ 2246 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Hospital E1kton Ceci1 8. Date of Birth
JAN 12, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 💢 M 2 🗆 F Michigan Director 159-32-2717 73 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10h Counts 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 V No Pennsylvania Chester Phoenixville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 177 Stewarts Court 19460 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married à Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72. In and Mental Hygiene. Is marked other than "r Drilling Equipment Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Engineer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard A. Flogaus Helen Stephan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda N. Flogaus/Wife 177 Stewarts Court, Phoenixville, PA 19460 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State May 2012 R. A. Ferris & Co., Inc. 4 Donation 5 Other (Specify) West Chester, 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Myocardial interesson. Disease Physician/ Artery Coronary disease or condition Medical resulting in death) Due to (or as onsequence 5 days. Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of, Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law has autopsy performed' death? certificate 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) No မ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manurer of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral 5 Pending work? 1 Yes 2 No Accident Investigation Suicide
Homicide Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical The Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Let Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number harma D66176 MA 2012 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar VINAY SHARMA.

31. Date filed (Month, Day, Year)

Mb;

LOGAUS

106 BOW STREET, GLKTON

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY Day Physician/ **GAYNOR** 2012 RANDOLPH 8, 10:56 A M Medical 4a. Facility Name (if not institution, give street and number)
4900 Maury Place 4b. City, Town, or Location of Death 4c. County of Beath **Examiner** Oxon Hill 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 64 Months Days Hours 1948 March 10, 217-44-1145 Maryland **Director** Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c, City, Town or Location Examiner must be notified at Director Md. Oxon Hill P.G. 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 4900 Maury Place 20745 U.S.A. 23a Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give VIETN Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ю þ 1 Never Married 2X Married ve VIETNAM Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates. **ERA** traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Fed Gov. 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Protective Srvice Be 17. Father's Name (First, Middle, Last) Columbus Gaynor 18. Mother's Name (First, Middle, Maiden Surname) Ella Hopkins and Mental F ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Verjena Gaynor 4900 Maury Place Oxon Hill Md.20745 other 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Cheltenham Cemt. May16,2012 Cheltenham, Md. 4 Donation 5 Other (Specify) 20001 Signature of Fundral Service Licensee 22. Name and Address of Facility Robinson Funeral Home 1313 6th St.NWWash 23a. Part 1/Enter the disease, or complications that caused the deatt/. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final CHRONIC OBSTRUCTIVE PULMONARY DISEASE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to him reclute cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Directo for the processoriance offiattending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burnelsed filled in by the funeral director, page 2 should be detached for use as the burnels. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Day 5 Other (specify) Pregnant at time of death P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, **ESSENTIAL HYPERTENSION** 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available HEART FAILURE 24a. Was an Was a. autopsy perform ?? prior to completion of cause of death? 1 Yes 2 No 1 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 X No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

DHMH 17 Rev 7/2009

29c. License number

KAREN ANN BLACKSTONE, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688

MD# 33255

29d. Date signed (Month, Day, Year)

MAY 9, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 16580 For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 12:40 PM Joseph Melvin Graves May 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown Social Security Number Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Hours 85 Director Maryland 217-28-8328 01/27/1927 Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 X No Maryland St. Mary's Avenue 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be with t Funeral 20609 USA 21599 Abell Road death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify. Yes. Give Specify. 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene, Important: If item 27 is marked other than any injury or other traumatic and ince. 8 Union School Shipwright Be 17 Father's Name (First Middle Last. 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Parran Graves Agnes Gertrude Arnold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Marie Graves/ Wife P.O. Box 353 Avenue, Maryland 20609 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/15/2012 4 Donation 5 Other (Specify) Sacred Heart Bushwood, Maryland 22. Name and Address of Facility – Gardiner Funeral Home P.A. of Funeral Servin Heliaek roune 41590 Fenwick Street Leonardtown, MD 20650 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each lin Immediate Cause (Final Onset and Death Physician/ Caro disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence Exami intestina burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician use as the burial Physician/Medical certificate be 51 IF FEMALE s, outcome of pregnancy Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atten in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Day Year Pregnant at time of death detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an page 2 s has autopsy performe certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes ည 1 🗌 Inpatient 2 🗙 ER/Outpatient 3 🗌 DOA 24 hours after death.

Funeral Director: After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 5 \square Pending work?
1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined

State Registrar

Medical

29a. Certifier

only one 29b. Signature

31. Date filed (Mo

3

and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 2012

Hospital

within 2

Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

10

Registrar's Signatur

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Winifred Mae Gateau 2012 12:20 A M May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F Days Hours Min. 08/01/1922 **Director** 215-62-8435 89 Pennsylvania Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 24754 Half Pone Point Road 20636 United States items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Medical Examiner 14. Race - American Indian þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify "natural", 3

Widowed 4 □ Divorced Completed Specify: Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the Homemaker Own_Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Michael Hill Bertie Viola Knipple 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau once. Patricia (A. Muchow P.O. Box 213, Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hollywood, Maryland John's Cemetery 105/16/2012 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Selvine Licensee | Michele Brinsfield MO 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition ellure Respirato Physician/ Onset and Death Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-1 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be detent 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 1 🗌 Yes 2 No 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifle 29d. Date signed (Month, Day, Year) 05/12/2012 D060473 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25500 Point Lookout Road, Leonardtown, MD 20650 Mehrdad Akhlaghi, M.D. 31. Date filed (Month Day, Year) State MAY 1 5 2012 Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation	5 🗌 Other (S		State	St.	John's				7/2012		Ho11			
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Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Acath	
Physician Month Day Ye	3. Time of Death
Month Day May 12, 2012 Month Day May 12, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County	
5 Locust Court Port Deposit Cecil	
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY Months Days Hours Min.	9. Birthplace (State or Foreign
140-80-6498 1K M 2 F 41 Yrs. 05/26/1970	Country) NJ
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	ribute to the cause of death?
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one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. OCME May 13, 26	
296. Signature and title of certifier 296. License number O.C.M.E. OCME May 13, 26 30. Name and address of person who completed cauke of death (Item/23a)	
296. Signature and title of certifier 296. License number O.C.M.E. OCME May 13, 26 30. Name and address of person who completed caute of death (Item/23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
296. Signature and title of certifier 296. License number O.C.M.E. OCME May 13, 26 30. Name and address of person who completed cauke of death (Item/23a)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16584 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 05 2012 Lucille Hawkins 8:35 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince George's Magnolia Nursing Center Lanham 8. Date of Birth (Month, Day, Year 03 15 1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** Months Days Hours Min. 1 M 2 X F Country) **Director** 579-05-4310 99 DC Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3600 B Street SE #122 20019 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: Black 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 | and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor CTA 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mamie Smith Walter Barringer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health ar ant: If item 27 is Sharon Lawson/Daughter 5424 C St. SE Washington, DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 05/14/2012 | Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 21. Signature of Funeral Service Lice isee 22. Name and Address of Facility Marshall-March Funeral Home malen 4217 9th St. NW Washington, DC 20011 part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death athensuentic heart disease Immediate Cause (Final Phylician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 gronths?

1 Yes No
9 Unknown signed by the atte Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate b Yes 2 completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 🗆 📉 မ 1 Inpatient 2 ER/Outpatient 3 DOA rsing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident work? 5 Pending 2 🗌 No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined e Funeral L Certifying Physician Medical Examiner To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier er. On the basis of example of the basis of example of the basis of th mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Sonja Wyche, MD 8200 Good Luck Road Lanham, MD 20706

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ David Nelson Hayes 05 10 2012 6:59 Ρ Medical 4c. County of Death 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Civista Medical Center La Plata <u>Charles</u> 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Hours Min (Month, Day, Year) Director 220-58-6696 1**X** M 2 □ F 60 Yrs. 10/05/1951 Washington, DC Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director be notified Maryland Charles Waldorf 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a 14003 Mount Eagle Lane 20601 USA Examiner must "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Black, White, etc. by 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Law Enforcement Narcotics Detective 12 Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Garland Hayes, Sr. Gladys Mae Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Jane Hayes / Wife 14003 Mount Eagle Lane Waldorf, Maryland 20601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 😾 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Trinity Memorial Cem | 05/17/2012 Waldorf, Maryland Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee M00817 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Road Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ IN YOCHROSEL INFARCTION disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Litter University Cause (Disease or injury Exami that the death certificate be executed and I-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the SS IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 9 Unknown Month Day Year the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown トノイヤミスファレスロン Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPER CHOLESTONOLIMES has page 2 performed cate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this funeral (28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred Certificate: Hospital or Attending **X** Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗷 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year, -148876 10) Rme 30. Name and address of person who completed cause of death (Item 23a) (Type, Print MICHIDEL 31. Date filed (Month, Dav. Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month ŽÕ12 8:00p.m.^M May 16 Walter Lee Hood 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death St. Mary's California 45824 Church Drive If Under 24 Hrs.
Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months 248-92-6546 1**X** M 2 □ F Yrs 62 04/25/1950 South Carolina Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Maryland | St. Mary's California 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 45824 Church Drive 20619 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Xyes 2 No Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify. 3 Divorced 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Metro Train Operator Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Lee Hood, Sr. Mattie Lene Shannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Ruth Smith/Sister P.O. Box 41062, Greensboro, NC 27404 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 05/23/2012 Columbia, SC Jackson Nat. Cem. Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of). Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnan 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Unknown

Physician. Medical Examiner

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attending physician

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this certificate

24 hours after death. Funeral Director: After

within 2

Hospital

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filled in by the

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

Examiner

Funeral

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28a-f show

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Certificate: To

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10a. State

within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

al Hygiene.

permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event. th

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🛱 No

23e. Did tobacco use contribute to the cause of death?

25. Was case referred to medical examiner's 2 **N**No Manner of Death

1 Natural

29a. Certifier

(Check

2 Accident
3 Suicide
4 Homicide

Hospital 28a. Date of injury (Month, Day, Year) 5 Pending Investigation

1 Inpatient 2 I ER/Outpatient 3 I DOA 28b. Time of iniury

4 Nursing Home 5 X Residence 6 Other (Specify) 28c. Injury at work? 2 🗌 No

29c. License numbe

26. Place of Death (Check only one)

28d. Describe how injury occurred

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Samuel Foster 110 Hospital Road, Suite 303, Prince Frederick, MD 20678

(a) porte State Registrar

31. Date filed (Month, Day, Year, Registrar's Signature MAY 18 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	laryland		rtment of I tificate of I		d Mental	Hygier Reg.	ne 2	012	16587
			Decedent's Name (First, Middle,	Last)					2. Date	of Death			3. Time of Death
	Physicia Medic		James Solomon H	ogue					Monti Apr:		Day 201	Year 2	10:30 A M
	Examin		4a. Facility Name (if not institution,	give street and number)			4b. City, Town, o	r Location of D	eath		4c. County	of Death	
مر	<u></u>		Holy Cross Hosp	ital		for limb for all and a	Silver If Under 1 Year	Spring		of Dinth	Mont	gomer	
	Funeral Director		5. Social Security Number 247-88-0087	6. Sex 7. Ag	ge (In yrs. last	- "	Months Days			h, Day, Yea	r)	9. Birtinpi Counti	ace (State or Foreign ry)
			Usual Residence of Decedent	1 22 101 2 1	61	Yrs.			Feb.	14,1	951	South	Carolina
	f sho	tor	10a. State 10b. County		10c. City, 7	Town or Loca	ation					10	d. Inside City Limits
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	th the 3a or t be n		10e. Street and Number				10f. Zip Code					What Count	
	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral	11504 Grandview	Avenue 12. Was Decedent	Ever in IIS	13 W	20902 /as Decedent of H	lispanic Origin	7 (Specify Yes o			State: ce - America	
0	or ite	by Fu	1 X Never Married 2 Marri	Armed Forces?		If If	Yes, specify Cuba	an, Mexican, P	uerto Rican, etc	:.)	Bla	ck, White, e	tc.
2	rs afte		3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1	Yes 2 X No	Specify:			Specify	Black	τ
9500-612	"natu	ompleted	15, Deceden (Specify only highes	t's Education			ent's Usual Occup ind of work done		workina	16b	. Kind of B	lusiness/Ind	ustry
7	within 72 hours after giene. er than "natural", or the Medical Exami	E O	Elementary/Secondary (0-12)	College (1-4 or		Ìife. DC	NOT use retired)				- •	0	
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ano	be file	10	Benjamin Crosby						nia Dawl		or carriar.	0)	
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altımore,	of He fitem	- 8	20a. Method of Disposition		20b. Plac	ce of Dispos	sition (Name of atory or other pla		Date			- City or To	
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Balt	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once.	Į,	21. Signalure of Funer Scride Li	Persee		22. 7	Name and Address 400 Geor	ess of Facility]	AcGuire	Funer	ral S	ervic	
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ROX	leath e atte id for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant 9 Unknown	at time of dea		Ectopic pregnan Other (specify) _	су			M	onth	Day Year
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Division of Vital Records,	law re nas bu e 2 sk	nple							24a.	Was an autopsy performed			sy findings available npletion of cause of
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ta	ician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			_ lott	or!	Check only one			-	_
<u>-</u>	Phys	2	1 Yes 2 X No 27. Manner of Death	1 K Inpa 28a. Date of inj	tient 2 El	R/Outpatient 8b. Time of	28c. Inju	4 □ Nurs	ing Home 5 2	Residence cribe how in			
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2	s after s all Direction		The months	building, e	tc. (Specify)				City	or Town, St	a re)		
_	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funderial Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Medical	(Check 2 Medical E	Physician: To the best of xaminer: On the basis of Nurse Practitioner: To t	examination a	and/or investi	gation, in my opin	ion, death occu	rred at the time,	date and pl	ace, and dı	ue to the cau	se(s) and manner stated.
	Fo the within Fo the complex	Σ	only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Fractitioner: 10 t	ing near or trily	knowleage,	29c. Licens		and prace, and the			ed (Month, E	
	2		- CMalo	N			D686	81		Anı	ril 2	9, 20	12
			30. Name and address of person v	who completed cause of	death (Item 2	3a) (Type, Pi		<u> </u>		LAP.) , LU	
			Charu Maheshwa	ry 1500 For	est_G1	en Roa	ad_Silve	r Spri	o Mary	12nd	2091	0	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16588 State
Registra MEND#25.27.28A-FoerMD,5/9/12; EMN,Mo@ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0.5 Physician/ HARTZOGE 11:50 AM DUISE 2012 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner SPRING MONTGOMERY CENESIS LAYHTLL CENTER SILVER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** N.C. 1 □ M 2 🛛 F Hours 5/26/4927 245-30-7569 84 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Funeral Director Olney MD Montgomery 1 🗆 Yes 2 🔀 No 10f. Zip Code 20832 10e. Street and Number 10g. Citizen of What Country? 4439 Morningwood Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retireu) Supervisor Textile Mill Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname)
Sally Gentry 17. Father's Name (First, Middle, Last) ည Edward Draton Boggs 19a. Informant's Name/Relationship (Type, Print) bb. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4439 Morningwood Drive Olney, Md 20832 Glenn R.Hartzoge Jr/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 X Removal from State 5/12/2012 Salisbury, N.C. Rowan Mem. Park 4 Donation 5 Other (Specify) 21. Signatur f Funeral Service L PHNME TO PADOS RENALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician/ .e Spiratory disease or condition resulting in death) Medical Due to (or as a consequence of) TWO Examiner WHIEKS Osis Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Bone been signed by the attending physician and should be detached for use as the burial-transit Osteomyel WEEKS Hospital or Attending Physician; The law requires that the death certificate be executed ATION APPROVED BY MEDICAL that initiated events resulting in death) Last Due to (or as a consequence of) UNKNOWN Physician/Medical S Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Other (specify) Pregnant at time of death Yes Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pothyroidism, Left 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dement pertension, After this certificate has funeral director, page 2: autopsy performed' Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 🙀 No 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred iniury 5 Pending rain within 24 hours after deatn.

To the Funeral Director: Aft 2 X Accident Probable Fall Investigation 2/12/2012 Unknown 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 4439 Morningwood Dr.Olney,MD 20832 home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 46895 Telile, mo 05/05/2012 Jung 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pre Road, Silver Spring, MD 20906. Bei 3227

DHMH 17 Rev 7/2009

State

Registrar

. Registrar's Signature

TELELE, MA.

Y 09

31. Date filed (Month, Day, Year)

			Pleas	se Type or Pr							•			.	
		For		State of M	1arylan					nd M	lental Hy	gie	ne 201	2 16	58
		State Registrar					Certifi	icate of l	Death			Reg.			
Physicia	n/	Decedent's Name									2. Date of De Month	ath	Day Year	3. Time of	Death
Medic	al	Cliffor	-		mael		1				05	05		18:50) M
Examin	er			ive street and number) entist Hosp	vital			. City, Town, o		Death			4c. County of Dea		
Funeral		5. Social Security N		. Sex 7. A	ge (In yrs. I	ast birthd	ay) If	akoma I Under 1 Year	If Under 24		8. Date of Bir	th	Montgome 9. B		r Foreign
Director		126-54-9	806	1 X M 2 □ F	90	Yr	s. Mo	onths Days	Hours	Min.	07/05/	192		ountry) Guyana	a
d now tt	Ļ	Usual Residence of 10a. State	Decedent 10b. County		10c Cit	v. Town c	r Locatio	20						10d. Inside Cit	
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or 28	Dire	DC 10e. Street and Nun	mber		l w	ashi		0f. Zip Code				10g.	. Citizen of What C		
with t	Funeral Director	6614 Bla	ir Rd.	NW				20012				U	SA		
items items		11. Marital Status		12. Was Decedent Armed Forces		S.	13. Was	Decedent of H	lispanic Origin	n? (Spec	city Yes or No-		14. Race - Am		
after c	l by	1 Never Marr		d 1 Yes 2 1				Yes 2 X No		1 001101	110011; 010.)		Specify: B		
ours atural	Completed	3 Widowed	4 Li Divorced	Year or Dates.		162 D		s Usual Occup				101			
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withir giene er th		12	Oliday (0-12)	College (1-4 of	J+)	Sal	esma	n				ΑŢ	pliance		
filed tal Hy d oth event	To Be	17. Father's Name (First, Middle, Las	st)					18. Mother	's Name	(First, Middle,	Maio	len Surname)		
uld be Meninarke narke	Ė	Ivan Is							Rutl		Brand			****	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na											y or Town, State, Z	lip Code)	
and Healt tem 2		Doris Is 20a. Method of Disp		ire	20b. F			<u>lair Ro</u> n <i>(Nam</i> e of	d. NW V		ington		OC 20012 C. Location - City of	r Town, State	
age 1 ent of ht: If i			☐ Cremation 3 5 ☐ Other (Sp.	Removal from State	e c	emetery,	cremato	ry or other plac					centwood		
mit. P partm portar r injur		21. Signature of Fu			FO	LL L.							h Funera		
Depar Impo any ir		mat	C-ha	Leva m	105	7							DC 20011		
				omplications that cause y one cause on each lir		h. Do not	enter the	e mode of dyir	ng, such as ca	ardiac o	r respiratory ar	rest,		Approximate Interval Betw	
Physician/		Immediate Cause (disease or condition		a_Respira	atory	Fai:	lure							Onset and D	eath
Medical Examiner		resulting in death)	4	Due to (or as	a consequ	uence of):									
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eath certifica attending p I for use as t	cian,	23b. Was decedent in the past 12 in	months?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant	2 Feta	al death		topic pregnan	су				23d. Date of d Month		'ear
re deg	ysic	1 Yes 2 Unknown		g 🗆 Unknown		Jean	3 🗆 0	ner (specify)							
that the	by P	Part II. Other signif	ficant condition	s contributing to death	but not res	ulting in t	he unde	rlying cause gi	ven in Part I.		23e, Did to	obaco	co use contribute	to the cause of de	eath?
quires en sig uld be	ed t										1 🗆	Yes	2 🗆 No 3 🗆	Probably 4x L	Jnknown
aw rec as bee 2 sho	Completed										24a. Was autor		prior to	utopsy findings a	
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ician: certific ector,	Be	25. Was case referre examiner?	_	Hospital:				26. P	lace of Death	(Check	only one)				
Physical direction	. To	1 L Yes 2 L 27. Manner of Death	_XNo h	1 X Inpa	tient 2 urv	ER/Outp		DOA 28c. Injur	4 L Nurs		ne 5 Resid		6 Other (Spe	cify)	
nding tth. : After e fune	Certificate:	1 Natural 2 Accident	5 Pending Investiga	(Month, Da		inju		work			ou. Describe i	1011	ijary ocoanog		
Atter er des ector by the	ərtifi	3 Suicide 4 Homicide	6 Could no	t be	jury - At ho	me, farm	, street, t	factory, office		2			and Number or R	ural Route Numbe	er,
ital or ins after al Dir led in	al Ce			bullaing, e	и. (эреспу	·/					City or Tow	vn, St	ate)		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2	Medical Exa	thysician: To the best of aminer: On the basis of lurse Practioner: To the	examination	n and/or ir	rvestigati	on, in my opini	on, death occu	urred at	the time, date a	and pl	ace, and due to the	cause(s) and man	ner stated
Vithi To th	1	29b. Signature and	title/of certifier	Shahe	u		MD	29c. Licens	e number	,		29d.	Date signed (Mon	th, Day, Year)	
30		h 1		no completed cause of	death (Item	1 23а) (Туг	_	Lylla	Shaha	/ /p , M	<u></u> Д	10	- 1 0	11-	
		31. Date filed (Monta		1 AU	emic Sian	ture	10	Elim	0 /	au	h M	77	209	13	
Stat Registra		AAY A	2012	32. Regist	rars Signal	ture	•								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	State of Mary		rtment of He tificate of De			liene 20	112	16590
Physician	,	Registrar 1. Decedent's Name (First, Middle, Last) ELEVA C TANUS				2. Date of Dea May 3,	th	Year	3. Time of Death 10:15pm
Medica Examine	1	ELENA C. IANUS a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo		may 3,	4c. County		
Funeral	4.		lon Ctr.		If Under 24 Hrs.	8. Date of Birth	Montg		ace (State or Foreign
Director		546-91-3857 Usual Residence of Decedent	88 Yrs.	Months Days		(Month, Day,		Roma	
yland -f show ed at	cto	10a. State 10b. County	oc. City, Town or Loc					10	0d. Inside City Limits 1 Yes 2 X No
he Mar or 28a e notifi	ᅙᅡ	Maryland Montgomery S Oe. Street and Number	Silver Sp	10f. Zip Code			10g. Citizen of V	Vhat Count	
s 23a nust be	Funeral	707 Kerwin Road		20901			United		
J30 s after death al", or item Examiner n	2	11. Marital Status 1	lf	Vas Decedent of Hisp Yes, specify Cuban, ☐ Yes 2 🏋 No	Mexican, Puerto	ecify Yes or No- Rican, etc.)	Blac	e - America k, White, e Whit	tc.
ire, Maryland 21215-UU30 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give h	ent's Usual Occupati ind of work done dur O NOT use retired)	ion ring most of work	ing Ukn	16b. Kind of Bu	usiness/Inc	^{lustry} Ukn
be filed wil ental Hygie ked other ic event, th	a l	17. Father's Name (First, Middle, Last) Ukn		1	18. Mother's Nam	e (First, Middle, i	Maiden Surname) Ukr	1
Maryland 12 should be filed 14 should be filed 15 is marked off 27 is marked off 17 traumatic event		19a. Informant's Name/Relationship (Type, Print) Sherry Davis (Guardian)		g Address (Street and					ode) e, MD 20850
Tore, ige 1 and nt of Hez it: If item r or othe		1 Burial 2 👿 Cremation 3 🗆 Removal from State		natory or other place)	1 1142	Date 4,	20c. Location -	-	
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or othe		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses (MO)	22	itan Crem. . Name and Address O East Dee	of Facility De	Vol Fune	eral Hon	ne	
H		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	1						Approximate Interval Between Onset and Death
Ph, sician/ Medical		disease or condition resulting in death) Pneumonia Due to (or as a co						1	Days
Examiner	-	Sequentially list conditions, if any, leading to immediate b. Dementia Due to (or as a co	Advanced	_				- 1	Tears
outed nd had had had had had had had had had ha	Examiner	Cause (Disease or injury that initiated events							
60 ate be exemply sician a the burial-	dical E	resulting in death) Last Due to (or as a co	onsequence on.						
Box 687 death certificate attending ped for use as	ĕ∣	in the past 12 months? 1 ☐ Yes 2 😾 No 4 ☐ Pregnant at till	Fetal death 3	Ectopic pregnancy Other (specify)				ite of delive	ery Day Year
that the ned by the detach	y Phy	Part II. Other significant conditions contributing to death but	not resulting in the u	inderlying cause give	en in Part I.	23e. Did to	bacco use cont	ribute to th	e cause of death?
ds, I	ted b	Failure to Thrive, Hyperte	nsion, De	pression		1 🗆 '	Yes 2 X No	3 Prot	pably 4 🗆 Unknown
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Completed by					24a. Was autop perfo	rmed?	Were autop prior to condeath? 1 \(\sum \) Yes	osy findings available mpletion of cause of
/ital sician: certific director	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No Hospital: 1 ☐ Inpatient	2 ER/Outpatier	Othor	ce of Death (Chec	<i>k only one)</i> ome 5 □ Resid	dence 6 □ Oth	er (Specify)
on of \ nding Phy ath. r. After this e funeral o	Certificate: To	27. Manner of Death 1 Natural 5 Pending (Month, Day, Y) 2 Accident Investigation	28b. Time of	28c. Injury a work?	at		ow injury occurr		
Division of To the Hospital or Attending Physithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Director.		3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury building, etc. (1)	- At home, farm, str Specify)	eet, factory, office		28f. Location (S City or Tow	Street and Numb vn, State)	er or Rural	Route Number,
e Hospit 24 hour e Funera sletely fill	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examonly one) 3 Certifying Nurse Practitioner: To the basis of examonly one)	mination and/or inves	tigation, in my opinion	 death occurred a 	at the time, date a	ınd place, and du	ie to the cai	use(s) and manner stated.
Withir Somp	2	29b. Signature and title of certifier **Man Suman Sum	٨	29c. License i	number		29d. Date signe	d (Month, i	Day, Year)
		30. Name and address of person who completed cause of dear	th (Item 23a) (Type, F	Print)		lver Sp			
Stat Registra			Signature		, ,		0,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Ker be Physician/ 6:10AM VICE 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Charles County Nursing Facility LaP1ata Charles Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 577-26-2542 **Director** 1 M 2 F 12/15/1922 Maryland 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2xxNo Maryland Charles LaPlata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 10200 LaPlata Road 20646 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. γ 1 Never Married 2 Married 1 Yes If Yes, Give Saltimore, Maryland 21215-0036 1 Yes 2XX No Specify: White Specify: 3 🛚 Widowed 4 🗌 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) 12 years College (1-4 or 5+) Homemaker In Home and Mental Hygien is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important; If item 27 is marked any injury or other traumatic ev ပ Havenner Florence В. Johnson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence Thompson / Sister 12729 Pearson Drive Waldorf. Maryland 20b. Place of Disposition (Name of cometery, crematory or other place)
St. John Broadcreek Cem. 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 05/11/2012 Ft. Washington, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature of Juneral Service Licer 6160 Oxon Hill Rd. Oxon Hill Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Fouluse Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of and that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical The law requires that the death certificate be Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death by the Unknown Unknown P.O. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No Natural 5 Pending М Accident
Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10°

Registrar

30. Name and address of person who

ause of death (Item 23a) (Type, Pricklon B Val SteB, Glen Buline, MD, 2106)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 16592 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 $a^{\,\scriptscriptstyle{M}}$ 1:30 Barbara A. Kelly $M \ni V$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Gilchrist Hospice Care If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Age (In yrs. last birthday) Hours Min (Month, Day, Year) **Director** 1 M 2 XF 205-32-3306 74 12/19/1937 PA 28a-f show "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Columbia MD Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21044 United States 6212 Bright Plume 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare Nurse should be filed with and Mental Hygien 7 is marked other tl Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lucille Marie Collins Michael Lester Henneforth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health a item 27 i 4041 Chariots's Flight Way Ellicott City, MD 21042 Department of Health Important: If item 27 any injury or other to Leeann K.Kelly-Judd - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05/11/2012 Ardent Crematory Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Na 2007 disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last the burial Physician/Medical Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ led by the atten detached for u in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à cate has been sig page 2 should b 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 🗌 Yes 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending n 24 hours after death.

Pe Funeral Director: Aft pletely filled in by the full. 1 ☐ Yes 2 ☐ No Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b, Signature and title of certific D64395 MAY 11,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA, MA 21044 6336 CESAR LANE 10 DOBERMAN, MD DANIELLE

Registrar

DHMH 17 Rev 06-2011

State

legistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 16593 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 05707/2012 FAYE S. KNOWLES 1316 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 2012 6. Sex 8. Date of Birth **Funeral** GA Country) 1 🗆 M 2 🔀 F Hours 0370371938 74 256-58-4099 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland **Funeral Director** notified 28a-f 1 XYes 2 No MD Montgamery Potomac 10e Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? must be r USA 9424 Copenhaver Drive 20854 ural", or items 2 I Examiner mus 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Deceso... Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 Widowed 4 X Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Asbury Methodist than Elementary/Seconday (0-12) College (1-4 or 5+) Retirement Community Receptionist ed other years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H If item 27 is marked of Ir other traumatic even ပ္ William Edward Smith Virginia Callaway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) V. Spring K. Bingham/daughter 9424 Copenhaver Drive, Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o ō cemetery, crematory or other place, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Ardent Cremation Sv 05/08/2012 Hanover, MD 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Lice 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington Street, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ ardiac arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner eroscl oron Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial was Due to (or as a consequence of): the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be unit 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed page 2 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation empleted filled in by the Suicide 6 🗌 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed orcos, MI 9901 Medical Center Drive Rockville HO filed (Month, Day, Year) State MAY 08 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ ^{Day}012 CHONG KIM TUK 7, May 11:15 A^M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Village Health Care Center Montgomery Montgomery Village If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral Director** 1 🗙 M 2 □ F 214-47-0695 91 Nov. 8, 1920 South Korea Usual Residence of Dec 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland Gaithersburg Montgomery 10e, Street and Numbe 10g. Citizen of What Country? ò Funeral 23a South Korea 526 Skidmore Blvd. 20877 or items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give ò Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 Divorced Asian Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. other than " Ministry Elementary/Secondary (0-12) College (1-4 or 5+) 12 Transportation Government Employee and Mental Hygie is marked other Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ge 1 and 2 should be find of Health and Mental If item 27 is marked 2 Hak Yong Kim Chupyae Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 526 Skidmore Blvd., Gaithersburg, Maryland 20877 Hye Ra Kim/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Department of I Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/9/2012 Olney, Maryland Norbeck Mem. Park ature of Funeral Service Lice 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician/ Stage IV Bladder Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Acute Renal Failure Sequentially list conditions, if an leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and and Cause (Disease or injury that initiated events Sepsis Due to (or as a consequence of): resulting in death) Last the buris Physician/Medical Box 68760 83 IF FEMALE nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ρ in the past 12 months? Month Day Year Yes 2 No 1 Yes 2 L 9 Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 ☐ Yes 2 🔀 No mpletely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I only one) 29b. Signature and title of certifie

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Vinu Ganti
31. Date filed (Month, Day, Year)

MAY 08 2012

19529 Doctors Drive

D 41162

Germantown, MD 20874

May 7, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Lloyd Louis Kath Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** P.G. Renaissance Gardens at Riderwood Vill¤ge Silver Spring If Under 1 Year If Under 24 Hrs. Social Security Number 8 Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Mir (Month, Day, Year) 474-12-4702 **Director** 1 🖾 M 2 🗆 F 22, 1922 MN Nov. Usual Residence of Decedent f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Prince George's MD Silver Spring 10f. Zip Code 10a. Citizen of What Country? Funeral 3156 Gracefield Road, Apt. 215 20904 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc by 1 Never Married 2 Married Specify:White Baltimore, Maryland 21215-0036 r res, Give Year or Dates. 1943-45 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Editor Publishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edna Marie Dopp Arthur E. F. Kath and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tran Norma E. Kath/Wife eta156 Gracefield Rd., #215, Silver Spring, MD 20904 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Page 1 May 8, 2012 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD uneral Service Lidensee 21. Signature of Francis J. Collins Funeral Home Inc. chard Lateo 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Hepatocellular Carcinoma disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) P Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): use as the buria ding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pleural Effusions, Gastrointestinal Bleeding 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed? this certificate has ral director, page 2 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 🗆 No by the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar 30. Name and address of person who completed Julaine Harding, CRNP (Month, Day, Year)

31. Date file

DHMH 17 Rev 06-2011

ause of death (Item 23a) (Type, Print)
3110 Cracefield Road, Silver Spring, MD 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep. State of Maryland / Dep. Cel.	artment of Health and N rtificate of Death	/lental Hy	/giene 2	012	16598
	Dharisis	. ,	Decedent's Name (First, Middle, Last)		2. Date of D		Year	3. Time of Death
	Physicia Medic		DENNIS KERRY KYLE		MAY	11,	2012	6:06 P ^M
	Examin	er	4a. Facility Name (if not institution, give street and number) 1000 ALLWARD DRIVE	4b. City, Town, or Location of Death WALDORF			y of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of B	irth 4, Year) 954	9. Birthp	place (State or Foreign VIRGINIA
	d t tow	_	Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Loc	neation				0d. Inside City Limits
	farylar Ba-fst tified	ecto	MD CHARLES WALDO					1 ☐ Yes 2X XNo
	h the N sa or 2 be no	Funeral Director	10e. Street and Number	10f. Zip Code		10g. Citizen of		
	ath wit	uner	1000 ALLWARD DRIVE 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20601 Was Decedent of Hispanic Origin? (Spe	ecify Yes or No		S. A	
9	fled within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Xes 2 ☐ NaPOST—	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Bla	ack, White, e	etc.
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Maryland 21215-0036		To E	CHARLES DAY KYLE	18. Mother's Nam MARY	1 /	MONAGE	,	
Man	sho han 7 is trau	Ī		ng Address (Street and Number or Rura				
e,	and Hea em ther		20a. Method of Disposition 20b. Place of Dispo			20c. Location		
Baltimore,	Page 1 ment of ant: If it		4 Donation 5 Other (Specify)	REMATORY 17,	2012	ALEXA		
Balt	permit. Page 1. Department of 1 Important: If it any injury or o'	Į,	21. Signature of Funeral Service Licensee M00641 5	2. Name and Address of Facility ${ t RAY}$ 635 WASHINGTON	MOND AVE.,	FUNL. S	SERVI FA,MC	CE,P.A. 20646
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.					Approximate Interval Between
	Physician/ Medical	F IN	Immediate Cause (Final disease or condition resulting in death) ISCHEMIC HEART a. Due to (or as a consequence of):	DISEASE				Onset and Death
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189	sath certificate be executed attending physician and for use as the burial-transit	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	_		23d D	ate of delive	env
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л О	requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did	tobacco use con	ntribute to th	ne cause of death?
ds,	requires been sign				1 🗆			pably 4X Unknown
Division of Vital Records,	The law recate has be page 2 sh	Completed			per	s an 24b. opsy formed? 2 X No		osy findings available mpletion of cause of
E T	Physician: The law this certificate has ral director, page 2 :	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check		ZLANO	i Li ies	2 110
Ž	Physic this c	2	Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time o			idence 6 Oth)
ono	ath. rr. After	ficate	1 X Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No	204. 2000.120			
NISI	or Atta after de Directo in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office		(Street and Numb wn, State)	ber or Rural	Route Number,
Ω	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check 29a. Certifier (Check 2 Medical Examiner: On the poest of my knowledge, death	occured at the time, date and place, ar	nd due to the d	ause(s) and man	ner as state	d.
	the Hithin 24	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of gertifier	death occurred at the time, date and place	ce, and due to	the cause(s) and n	nanner as sta	ated.
			Date of long	#MD30325		MAY 17,		<i>Juji</i> , 1000/
-	14, Om		30. Name and address of person who completed cause of death (Item 23a) (Type, MARQUEZ A. MARQUEZ, M.D., VAMC, 50 IR		л СИТЫ <i>С</i> П			688
0	Stat	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature		POTITIO	OR,DO Z	U7 <i>LL</i> /	
	Registra		31. Date filed (Month, Day, Year) NAY 2 4 2012 32. Registrar's Signature ACCOUNTS 31. Date filed (Month, Day, Year)					

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Amend #23a per 92 State of Maryland / Department of Health and Mental Hygiene

**Topic State Amend #2 per fh TT 5/11 Certificate of Death 20b per Ft. TT 250 15212 6597

	Physicia		1. Decedent's Name (First, Middle, Last) William Lewis		te of Death 3. Time of Death onth 03 Year 15:57 P M
1	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
med .			Southern Maryland Hospital	Clinton	Prince Georges
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Dat Months Days Hours Min. (Mo	te of Birth 9. Birthplace (State or Foreign Country)
			Usual Residence of Decedent		/05/1947 FL
	ryland -f sho ied at	Director	10a. State 10b. County 10c. City, Town or Lo MD Prince Georges Upper M		10d. Inside City Limits 1 ✓ Yes 2 No
	ne Ma or 28a notif	Dire	MD Prince Georges Upper M 10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	e filed within 72 hours after death with the Maryland tall Hyglene. ad other than "natural", or items 23a or 28a-f show of other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	6204 Connaught Ct.	20772	USA
	death item	Fur		Was Decedent of Hispanic Origin? (Specify Yes f Yes, specify Cuban, Mexican, Puerto Rican,	s or No- 14. Race - American Indian, etc.) Black, White, etc.
920	s after 'al", o Exami	d by	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never More No. 1 No. 1 Yes, Give Year or Dates.	1 ☐ Yes 2 🕱 No Specify:	Specify: Black
21215-0036	2 hour "natur	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	16b. Kind of Business/Industry
121	iled within 72 il Hygiene. other than " vent, the Mer	Com	Flamonton (Consordant (O.10) College (1.4 or 5.) life, D	ONOTuse retired) ract Specialist	Federal Government
d 2	filed wi al Hygie d other vent, tl	Be	17. Father's Name (First, Middle, Last)		Middle, Maiden Surname)
/lan	ild be fil Mental narked atic ev	욘	Morris Lewis	Ada Thom	npson
Maryland	shou and is m		SCIONG-TEMIS I	ng Address (Street and Number or Rural Route	
e, r	and 2 and 2 em 27 em 27 ther tr		Franchescatewis / wife 6204	Connaught Ct - Upper	1
Baltimore,	or = o			osition (Name of natory or other place) Nat. Cem. 5-22-20 unk	Arlington, VA
altir	permit. Pag Departmer Important: any injury once.	1/4			kland Funeral Services
<u>m</u>	o a m e	(9)	Asel Tulland		Camp Springs, MD 20748
			23a. Part 1. Enter the disease complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	1 1	Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	vascular dise	ese onder
	Examiner		Lung Cancer		
	_ =	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	ecutec and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):		
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ox 68760	ificate ng phy as the	cian/Medical	IF FEMALE:		
9 x	th cert ttendir or use	ian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3		23d. Date of delivery Month Day Year
Bo		Physic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)	
P.O.	requires that the de been signed by the should be detached	y Pł	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	Be. Did tobacco use contribute to the cause of death?
ds,	quires en sig ould b	ted l			1 Yes 2 No 3 Probably 4 Unknown
CO	law re nas be e 2 sh	Completed by		24	4a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
Be	sician: The law r certificate has b lirector, page 2 s		CS Western Country and		☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
/ita	siciar s certii	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No Hospital: 1 □ Inpatient 2 ☑ ER/Outpatient	26. Place of Death (Check only o	Residence 6 Other (Specify)
of \	g Phy er this neral o		27. Manner of Death 28a. Date of injury 28b. Time of	f 28c. Injury at 28d. De	escribe how injury occurred
on	endin eath. or: Aft	fical	1 ☑ Natural 5 ☐ Pending (Iviontin, Day, Tear) Injury 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	work? M 1 ☐ Yes 2 ☐ No	
Division of Vital Records,	or Att after d Direct	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		cation (Street and Number or Rural Route Number, ty or Town, State)
	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Fundral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier 1 □ Certifying Physician: To the best of my knowledge, death (Check 2 □ Medical Examiner: On the basis of examination and/or inves only one) 3 □ Certifying Nurse Practitioner: To the best of my knowledge	tigation, in my opinion, death occurred at the tim	ne, date and place, and due to the cause(s) and manner stated.
	To the within 2 To the comple	2	29b. Signature and little of certifier	29c. License number	29d. Date signed (Mogth, Day, Year)
	Of a		30. Name and address of person who completed cause of death (Item 23a) (Type, It	Print) 1300 1300 3	10/7/12
	+		Anoop humar 7503 Surras	to The Clinton	1 Md 20735
	Stat Registra		31. Date filed (Morkh, Day, Year) 32. Registrar's Signature		
	3,34		and I have been been been been been been been be		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 16598 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ 14 6:30 a.₩ May Medical Deborah Jeanne LaQuay 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 48070 Windward Circle, Unit 104 Lexington Park St. Mary's If Under If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7 Age (In vrs. last hirthday) Social Security Number Funeral Months Hours Min (Month, Day, Year, 218-82-7958 **Director** 1 □ M 2 🗓 F 06/23/1960 51 Washington, DC Usual Residence of Decedent 28a-f shov aţ 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 X No Maryland St. Mary's Lexington Park 10f. Zip Code 10a. Citizen of What Country? ò Funeral 23a 20653 48070 Windward Circle, Unit 104 United States items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ?7 is marked other than "natural", or iter traumatic event, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) 12 Restaurant Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Donald David LaQuay Mary Louise Swain and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20653Tara Hamilton/Daughter 48070 Windward Circle, Unit 104, Lexington Park, MD Baltimore, tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 05/16/2012 | Charlotte Hall, MD Signature of Funeral Service 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsf 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Respiratory Failure Medical resulting in death) **Examiner** Years Chronic Obstructive Pulmonary Disease Sequentially list conditions, Examine ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that the death certificate be executed burial-tra that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 X No
9 ☐ Unknown for Month Day Year Pregnant at time of death signed by the a ld be detached 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Attending Physician: The law requires 1 K Yes 2 No 3 Probably 4 Unknown Records, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 No within 24 hours after death.

To the Funeral Director. After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Yes 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pendina Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 9 Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [29b. Signature and title of certi 056096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

1) eme

Rajbinder S. Gill,

31. Date filed (Month, Day, Year) 2012

M.D.

32. Registrar's Signature

24035 Three Notch Road, Hollywood, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16599 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dong N. Luu 2012 2:05 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2949 Saint Helen Circle Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Director 219-33-1588 1 **⊠** M 2 □ F 1930 Nov. 28, Vietnam 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23e or 28a-f s Examiner must be notified 1 ☐ Yes 2 🛣 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2949 Saint Helen Circle 20906 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. à 1 Never Married 2 X Married ☐ Yes 2 🔀 No within 72 hours after Baltimore, Maryland 21215-0036 Specify. Asian 1 ☐ Yes 2 🖾 No Specify: If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates ift. Page 1 and 2 should be filed within 72 hours artment of Health end Mental Hygiene. ortent: If Item 27 Is marked other than "natur injury or other traumatic event, the Model I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Doctor Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Nam Luu Bay Nguyen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thu Huynh/Wife 2949 Saint Helen Circle, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State May 9, 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, MD permit.
Departn
Importe
any inju 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. MO1505 500 University Blvd. W. Silver Spring MD_20901 23a. Part a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hepatic Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): attending physician and I for use as the burial-transit Liver Cirrhosis Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month g 🗌 Unknown 9 Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been significate has been significated and funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔑 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) May 8, 2012

Registrar

DHMH 17 Rev 06-2011

State

751 Rockville Pike, #13A, Rockville, MD 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Hon-Yuen Wong, MD

MAY 0.9 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5/6/12 5:57 P <u>William Merchant Lowerre Jr</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chevy Chase Montgomery 5310 Chamberlin Ave Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) **Director** 118-16-2111 1 🔀 M 2 🗆 F Yrs 85 07/21/1926 New York Usual Residence of Decedent f show 10a. State 10b. County 10c. City, Town or Location notified at Director 10d. Inside City Limits 28a-f 1 X Yes 2 No Montgomery Montgomery Village 10e Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be r with 9505 Duffer Way 20886 United States items 2 death "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, ed Forces? Black, White, etc þ 1 Never Married 2 Married 1 X Yes 2 □ No Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates. unknown White 1 Yes 2 X No Specify Specify: 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mandone." (Give kind of work done during most of working life. DO NOT use retired) Department of Energy than Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Nuclear Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Merchant Lowerre Kate Myrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5310 Chamberlin Avenue Chevy Chase, MD 20815 Phyllis M. Knowles / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🖾 Removal from State Cortland Rural Cemet. 6/29/12 Cortland, New York 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Joseph Gawler's Sons Willio 5130 Wisconsin Ave NW Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Lung Cancer with Metastatic Disease to Brain Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to for as a consequence of cause. Enter Underlying and The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): as the buria attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year 5 Other (specify) ģ Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ĝ should be Atrial Fibrillation 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 perform death? 2 No Yes 2 X No 1 Yes after death.

Director: After this certification of the funeral director, Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Private Hospital 1 Yes Other: 2 X No ပ 4 Nursing Home 5 Residence 6 X Other (Specify) Residence 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 24 hours Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and titl 29d, Date signed (Month, Day, Year) 2 29c. License number 20 D35579 05/07 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan J. Miller MD 8218 Wisconsin Avenue Suite 305 Bethesda, MD 20814

Registrar
DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

MAY 09 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registant NEND#20cperFH, 5/14/12; bMW, McCo Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ 2012 1:19 pm Robert Edward Lee Mau Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 2827 Vixen Lane Silver Spring Montgomery If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Funeral Hours 577-22-6721 **Director** 1**X** M 2 □ F 12/26/1921 90 Washington, DC Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10b County 10d Inside City Limits Director Examiner must be notified 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20906 U.S.A. 2827 Vixen Lane death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1945 Black White etc o. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 Widowed 4 Divorced 1946 Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the U.S. Government Personnel Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emma Helen Viedt Darwin Bird Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2827 Vixen Lane. Silver Spring. Maryland 20906 Lily W. Lee - Spouse 20b. Place of Disposition (Name of 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Silver Spring, Maryland 05/09/2012 Brentwood. Gate of Heaven Cem. Donation 5 Dother (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 21. Signatur of Hunera Hervi 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 3 Months Physician/ Liver Metastases disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** 3 Months Colon Cancer Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury sician and buria that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown a Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure Hospital or Attending Physician: The law requires 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Renal Insufficiency autopsy performed? Yes 2 X No death? 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending n 24 hours after death.

Funeral Director: Aft letely filled in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Accider 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 houTo the Funer
completely fi 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certific 29d. Date signed (Month, Day, Year) May 07, 2012 D21910

State Registrar 3921 Ferrara Drive, Wheaton, Maryland 20906

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Peter Sherer.

MAY 09 2012

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2012 Willie McCray May 0410 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Center Clinton Prince Georges 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs **Funeral** Min. Hours 1**X**□M 2□F Director 264-48-0107 76 28 Nov Florida 10a. State 10c. City, Town or Location at 10d, Inside City Limits Director r 28a-f si notified Marvland 1 X Yes 2 No Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be r Completed by Funeral 3223 Indian King Court 20602 permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner many injury or other traumatic event, the Medical Examiner many. 12. Was Decedent Ever in U.S. Armed Forces? U.S. 11 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give A 155 E0769 Year or Dates. 1 Yes 2 No Specify: Specify: Black 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Postal Clerk 12th. Postal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Willie McCrav Ruby Lee Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dickie McCray/ Son 1000 Jackson Blvd. Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H
Important: If ite
any injury or oth
once. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Huntt Crematory May 9, 2012 | Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENCEPHALO PATHY Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner STAGE Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events CottoLIC the burial-tran Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 424 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? after death.

Director: After this certificate has autopsy perform 2 No 2 M No Yes upletely filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature an 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) Dr. Timothy Ehiabor 7503 Surratts Road Clinton, MD. 20735

DHMH 17 Rev 06-2011

Registrar

Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and	Mental Hyg	iene 20	12 16603
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death		eg. No.	3. Time of Death
	Physicia Medic		Elizabeth Catherine Murphy		May May	8 ^{ay} 2012	
	Examin		4a. Facility Name (if not institution, give street and number) Southern Maryland Hospital	4b. City, Town, or Location of Death Clinton	1	4c. County of Prince	
	Funeral Director		5. Social Security Number 6. Sex 1. Age (In yrs. last birthday) $217-36-7864$ 1. M 2 \blacksquare F 80 \blacksquare Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year)	D. Birthplace (State or Foreign Country) MD
	and show d at	io	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	pcation			10d. Inside City Limits
	Maryl 28a-f notifie	irec	MD Charles Faulki				1 🗆 Yes 2 🙀 No
	with the 23a or	Funeral Director	10e. Street and Number 9630 Norris Dr.	10f. Zip Code 20632	1	0g. Citizen of What USA	
36	and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Lem 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at	ρ	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give	Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puert 1 Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)		American Indian, White, etc. Vhite
9-0	hours natura dical E	olete	15. Decedent's Education 16a. Dece	dent's Usual Occupation	deine	16b. Kind of Busin	
121	thin 72 ene. than " ne Med	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) life. D	kind of work done during most of wor IO NOT use retired) nemaker	Kirig	ŀ	Home
2 اور	filed wi al Hygie I other vent, ti	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nar	me (First, Middle, M	laiden Surname)	
Maryland 21215-0036	uld be i Menta narked natic e	은	George Edward Burch		ne Cecili		
	sh an is		Cathorino M Griceby/Daughter	ng Address (Street and Number or Ru Box 154 Faulkner			e, Zip Code)
Baltimore,	- P = 5		20a, Method of Disposition 20b, Place of Dispo		Date	20c. Location - Ci	•
<u>H</u>	permit. Page 1 Department of I Important: If it any injury or or		4 🗆 Boriation 3 🗀 Other (opeciny)	2. Name and Address of Facility	5/12/12	LaPlata,	, Md.
Ba	permit. Departr Import, any inji		M00945 A	rehart-Echols Fun			Į.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arre	5t,	Approximate Interval Between Onset and Death
	Medical	0 0	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	RAL EFFUSSIO	つと		Oriset and Death
	Examiner		Sequentially list conditions, b. REGIRATORY	Falure			
	ed sit	Examiner	dequentially if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	SUEDANSON	~A		
	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):	T T	77 (
09	ate be physicia the bu	dical	END STAGE /	CONEY TAIL	ure.		
. Box 687	requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date o	
ls, P.O.		by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribu	ute to the cause of death?
Record	The law ate has page 2	Completed			24a. Was ar autops perform 1 \(\sum \text{Yes}\) 2	y prid ned? dea	re autopsy findings available or to completion of cause of ath? Yes 2 No
ita	ysician: is certific director,	Be c	25. Was case referred to medical examiner? Hospital: Hospital: Impatient 2 FR/Qutpatient 2	26. Place of Death (Che		a □ au	
of V	ig Physical this neral di	te: To	27. Manner of Death 28a. Date of injury 28b. Time of injury 28b. T		dome 5 Reside 28d. Describe ho		Specify)
ion	ttending Ph death. tor: After thi the funeral	Certificate:	2 Sucident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	000 1		David Barris Musel
Division of Vital	al or Att s after d il Direct ed in by		4 Homicide determined building, etc. (Specify)	eet, ractory, onice	City or Town		or Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investorily one) 3 Certifying Nurse Practitioner: The best of my knowledge	stigation, in my opinion, death occurred e, death occurred at the time, date and p	at the time, date and place, and due to the	d place, and due to e cause(s) and mar	the cause(s) and manner stated. nner as stated.
	Voir Con		29b. Signate e) and title of certifier	29c. License number MD 6532		9d. Date signed (*)	Month, Day, Year)
	BU.S		30. Name and address of person who completed cause of death (Item 23a) (Type,			~ MA	20735
	State Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	hares			
			Total Co. Mar.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar 16604 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Clauder Muse Ear1 7:30 P M 2012 May 1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Bradford Oaks Nursing Home If Unde 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year, Months Hours Director 1 👿 M 2 🗆 F 77 203 26 8485 Nov 16, 1934 Philadelphia, Pa 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Clinton Prince George's Maryland 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with United States 20735 6310 Willow Way 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 0 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify **Black** 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working d Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leon Muse Ethel Clary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 6310 Willow Way, Clinton, MD 20735 Doloris Muse (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or otl 1 Burial 2XX Cremation 3 Removal from State 5/11/2012 4 Donation, 5 Other (Specify) Clinton, MD Lee Crematory 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Cardiar Ph_sician/ dden disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to jor as a consequence of cause. Enter Underlying Cause (Disease or injury Exami attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires Aphasia 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No Dementia 24a. Was an page 2 s autopsy perform Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) uneral director, Certificate: To Be Other: 4 👿 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 27 Manner of Death 28d. Describe how injury occurred iniury 5 Pending 1 X Natural Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

the Hospital

within 24 hcurs a

To the Fun ral E

completely filled State Registrar

Medical

29b. Signature and received my 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

D0052999

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number,

Ali Rahimian, MD 10403 Hospital Drive G-06, Clinton, MD 20735

31. Date filed (Month, Day,

4 Homicide

29a. Certifier

(Check

32 Registrar's Signatu backs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 16605 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 Physician/ 2012 McGee 29 7:25A Mae Willie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2203 Greenery Lane #203 Silver Spring Montgomery 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours Min. 233-62-6530 1 □ M 2 □**X Director** 12/17/1912 ALUsual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral 20906 USA 2203 Greenery Lane · death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married þ Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 ☐XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Self-employed Homemaker 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental H permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury exercises. ၉ Richard Prayer Pearl Prayer Lillie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2203 Greenery Lane #203 Silver Spring, MD 20906 Dr. Milton A. Walters/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/09/2012 Waldorf, MD Heritage Cemetery ure of Funeral Service Li 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 Indelson cart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 6 min disease or condition Medical resulting in death) Due to (or as a constiquence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) ed by the a 1 L Yes 2 N signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hdenocarcinoma 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No novexi 24a. Was an page 2 autopsy has certificate Yes 2 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1. Natural 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Pactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 21032 pleted cause of death (Item 23a) (Type, Print)

1. Date filed (Month,

MD

2033

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16606 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:36 PM MAY King 2012 Elease Mason Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Cheverly Prince George's Social Security Number 7. Age (In yrs. last birthday) If Unde 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Min (Month, Day, Year) 250-34-2030 **Director** 90 1 □ M 2 🗓 F SC 10/21/1921 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City. Town or Location 72 hours after death with the Maryland 10a. State Director 1X Yes 2 No MD Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20743 USA 407 Quarry Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2X No 3 ₩ Widowed 4 □ Divorced "natural", Completed Year or Dates traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If feen 27 is marked other than "na any injury or other traumatic event at a once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Housekeeper Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rosie King Lonnie Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George W. Mason, Jr./Son 407 Quarry Ave. Capitol Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Elizabeth Baptist Cem. 05/12/2012 Florence, SC 21. Sig thre of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIAC Immediate Cause (Final ARRHYTHMIA Physician. disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury The law equires that the death certificate be executed and I-tran that initiated events Due to (or as a consequence of): resulting in death) Last -purialphysician Physician/Medical Records, P.O. Box 68760 as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 9 Unknown 9 Unknown s Leen signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has te 2 4 1 Yes 2 No Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital Other: ပ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident work 5 Pending 1 Tes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D0068294

Registrar

DHMH 17 Rev 06-2011

30. Name and address of person

HOSPITKL

who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

3001

MD

BOTWE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death May 3, Physician/ 2**0**12 9:36 Henry Martin P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's 1908 Belfast Drive Fort Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, June 1, Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 2 M 2 D F ^{Year} 1942 West Virginia Director 69 579-56-3670 Usual Residence of Decedent shov 10b. County 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 No Maryland | Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1908 Belfast Drive 20744 United States ural", or items ? I Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Tes 2 No Specify: African "natural", Completed 3 Widowed 4 Divorced American Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Management Analyst Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) and Mental F is marked of မ Napoleon B. Martin Effie Francis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health are Important: If item 27 is any injury or other trau 1908 Belfast Drive Fort Washington, Md. 20744 Patricia Martin - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date May 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 2012 4 Donation 5 Other (Specify) Suitland, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. M00560 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Brain Cancer Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f g 🗌 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy perform 2 No 2 X No 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work?
1 \(\sum \) Yes 2 \(\sum \) No injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) Koucetchew, Mo)

Registrar

Jocelyne

Jocelyne Kouatchou

2012

31. Date filed (Month, Day, Year)

MAY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

201 East University Parkway

D63748

May 8, 2012

21218

Baltimore, Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2012 6:08 a.m. May Kathleen Wade Maguire Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's 42630 Clover Hill Road Hollywood If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 577-54-9336 **Director** Yrs. 08/26/1940 Washington, DC 71 Usual Residence of Deceden or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland St. Mary's Hollywood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a (Funeral United States 20636 42630 Clover Hill Road or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2 should be filed within 72 In and Mental Hygiene.
7 is marked other than "n College (1-4 or 5+) Elementary/Secondary (0-12) Defense Contractor Recruiter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Frances Logan 1 and 2 should b f Health and Mer tem 27 is mark Otis Darrel Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 42630 Clover Hill Road, Hollywood, MD Suzanne M. Maguire/Daughter item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 Burial 2 Cremation 3 Removal from State Brinsfield-Echols Cre 05/16/2012 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) Signal Service To Service Modern Modern Santivasci Modern 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 20650 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line. a. such as cardiac or respiratory arrest, Approximate nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death g 🗌 Unknown the P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? Yes 2 No has 25. Was case referred to medical 26. Place of Death (Check only one) Hospital or Attending Physician: funeral director. Be examiner? Hospital: Other: 4 Nursing Home 5 N Residence 8 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 1 Yes 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 2 Acciden work 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20650 40900 Merchants Lane, Leonardtown, MD Schmidt, D.O. Jennifer egistrar's Signatur 31. Date filed (Month

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended #20b**1 - State** TCHD, 5/10/2012, TLS Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 04^{ay} Physician/ Month 05-2012 McCl vment Carolyn 11:33 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot 102 Miles Lane Apt.# 106 St. Michaels 7. Age (In yrs. last birthday)
77 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Days 218-30-1621 1 □ M 2 🗶 F 08°-02°-1934 Md. **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified any once. 10d. Inside City Limits 10c. City, Town or Location 10a. State Director St. Michaels 1 🗆 Yes 2 🔀 No Talbot Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21663 U.S.A. 102 Miles Lane Apt.# 106 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Shores Cornelius S. Mi ldred Armentrout 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21522 Coopertown Rd. Tilghman, Md. 21671 19a. Informant's Name/Relationship (Type, Print) George Anthony McClyment/ Son Method of Disposition

1 ■ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 05/1^{Date}/2012 Md. Veterans Cem. East New Market, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Hartev & Ostrowski Funeral Home P.A. P.O. Box 518 St. Michaels, Md. 21663 Joseph 37 OSTRIUSK 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 1 Week Death Immediate Cause (Final Pulmonary Edema Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Years Chronic Obstructive Pulmonary Disease Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Insulin Dependent Type II Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Congestive Heart Failure 24a. Was an this certificate has ral director, page 2: performed? Yes 2 No 1 🗌 Yes 2 🗆 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA ၉ After thi funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural injury work' 5 Pending n 24 hours af er dea h. e Funeral D rector. Afte 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F 3 XCertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R124198 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.E. Delean-Botkin, C.R.N.P. 8579 Commerce Drive # 106, Easton, Md. 21601 31. Date filed (Month, Day, Year, 2. Registrar's Signature MAY 0 9 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death William | John McKean May 8, Physician/ 2012 1:35 a. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Bedford Court Assisted Living Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 140-10-7064 Director 1 X XM 2 - F Yrs 92 April 11, 1920 Washington, DC Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🛣 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3701 International Drive, #212 20906 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1944-46 1 ☐ Yes 2 X No Specify. Specify:White 3 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 end 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, <u>the Me</u> ury or other traumatic event, <u>the Me</u> Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Thornton McKean Agnes Lappin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3701 International Drive, #212, Silver Spring, MD 20906 Mary Straub McKean/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 8. permit. Page 1
Depertment of I
Important: If ite
any injury or of 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 2012 Alexandria, VA Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. lus 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician Advanced Prostate disease or condition Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). ending physician and r use es the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use es the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed; þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe certificate Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted Living Other: 4 Nursing Home 5 Residence 1 Yes 2 🔀 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27, Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funerel Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No М 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15+ D54566 May 8, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli, MD

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32. Registrar's Signatu

9801 Georgia Avenue. Silver Spring, MD 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Mav Physician/ 1830 РΜ Gertrude Mary McVey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil E1kton Union Hospital 9. Birthplace (State or Foreign Country) Pennsylvania Social Security Numbe . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth **Funeral** DEC 27. 1935 1 □ M 2 🗓 F Director 76 140-28-7804 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 💢 No Chesapeake City Marvland Ceci1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21915 United States 34 Briscoe Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 12 Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Caucasian 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Registered Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Samuel Weare Mary Dolan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James C. McVey/Husband 34 Briscoe Avenue, Chesapeake City, MD 21915 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May ^{Dat}6. 1 Burial 2 X Cremation 3 Removal from State West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. ris & Co., Inc. | 2012 | West Chester, PA 22 Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licenses 103 W. Stockton Street, Elkton, MD 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CEREBLO VASCULAL ACCI DENT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Year Month Dav Pregnant at time of death Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 뎯 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 1 Natural 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Br. Water of 05/16/2012 Dao 65733

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Registrar

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BUKPON, MI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RA

V- PULA

NARAYANA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 2148 Decedent's Name (First, Middle, Last) May 3,2912 Physician/ Ngassam Ngamga Anastasie Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, County of Death
Montgomery **Examiner** Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 2/197791945 691-05-4630 Cameroon 1 □ M 2 🕇 F 67 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits Silver Spring must be notified at Director Montgomery MD 1 🗌 Yes 2 🎞 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō Funeral items 23a Cameroon 20910 1220 Blair Mill Road #1004 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Il Hygiene. I other than "natural", or iter went, the Medical Examiner Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Secondary (0-12) College (1-4 or 5+) Retail Self employed e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname)
Luciene Yamogjeu 17. Father's Name (First, Middle, Last, Vincent Tchaptchet permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic and Number or Rural Route Number City of Town, State, Zip Codeling, Md Mill Rd #1004 Silver Spring, Md 20910 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street 1220 Blair Lambert Tchaptchet/Son Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 🔀 Removal from State 6/2/2012 Bangangte, Cameroon ly Cemetery 72/20 Dangard Service, P.A. 4 Donatio 5 Other (Specify) Signature 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Respiratory failure Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Plueral effusion Sequentially list conditions Due to (or as a consequence oi). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury End stage renal disease Exami The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last ng physician ar Physician/Medical Box 68760 d. attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown ę Month Dav Year Pregnant at time of death 5 Other (specify) ed by the a detached the g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed k should be det 23e. Did tobacco use contribute to the cause of death? þ ovarian cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed?

1 Yes 2 No 2 🗆 No or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 🔼 No 1 Yes 1 M Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred : After 1 1 🔀 Natural injury 5 Pending work?
1 Yes 2 No death. 2 Accident
3 Suicide Investigation after deatl 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital o within 24 hours aff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practition of: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) May 4, 2012 29b. Signature 29c. License number D67589 NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd Silver Spring, Md 20910 HaroldLawson MD

State

Registrar

31. Date filed (Month, Day, Year)

09 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ 2012 Melinda Kathryn Nickols 4:15 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey Hospice House Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Months Hours Min. (Month, Day, Year) **Director** 558-68-4462 1 □ M 2 🛣 F Yrs. Oct. 7, 1947 California or than "netural", or items 23e or 28e-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits 1 Yes 2 X No Maryland Montgomery Village Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20886 19417 Brassie Place, Apt. 102 United States hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 K No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White Specify: Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 el Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) e 1 and 2 should be filed with of Health and Mentel Hygle. If item 27 is marked other or other traumetic event, ₩ Property Manager Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph I. Priest Camille Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew Nickols / Son 14130 Arbor Forest Drive Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Depertment of
Importent: If it
any injury or o 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 2012 4 ☐ Donation 5 ☐ Other (Specify) Pine Grove Cemetery Mt. Airy, Maryland 21. Signature of Juneral Service Lice 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician, Adenocarcinoma of the Lungs with Metastases Medical resulting in death) Examiner Sequentially list conditions, Sequentially instructions, if any, leading to immediate cause. Little to identifying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): sician and burial-transit or Attending Physician: The lew requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day Year 9 Unknown this certificete has been signed by ral director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 K Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 🛣 No Yes 2 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? P Hospital: 2 🖾 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 K Other (Specify) Hospice Certificate; 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. I Director: After t 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hoepital o within 24 hours af To the Funeral Di completely filled in Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D37142 May 5, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Drive Geoffrey Coleman, M.D. Rockville, Maryland 20850 32. Pagistrar's Signature 31. Date filed (Month State 8 2012 MELLINE Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2012 Year 5 John Stanley Organ May 3:20p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1006 Seneca Drive Frederick Frederick . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 16, 1922 . Age (In vrs. last birthday 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Min. Months Davs Hours **Director** 182-12-5277 89 Pennsylvania Usual Residence of Decedent 28a-f show 10b Count 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director notified 1 X Yes 2 □ No Maryland Frederick Frederick 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe 23a 1006 Seneca Drive 21703 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1 → Yes 2 → No Black, White, etc. 'natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed If Yes, Give Specify: 3 X Widowed 4 Divorced Year or Dates. WWII White ed other than "natur event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Ith and Mental Hygiene.
27 is marked other than r traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Computer Programmer Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Burford Organ Agnes Thomson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a item 27 i Margaret Procario / Daughter 1006 Seneca Drive, Frederick, Maryland 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or otf 20c. Location - City or Town, State ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Creamtory Inc.5/7/2012 Frederick, Maryland. 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 21. Signature neral Service L Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest Interval Between Immediate Cause (Final Onset and Death Physician/ na disease or condition Medical resulting in death) **Examiner** Seaso Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to io burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Yes 2 No the detached 9 Unknown ģ Part II. Other significant conditions contributing to death bot not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by funeral director, page 2 should be DOY 1 Yes 2 X No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an nas | autops death? certificate 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 2 ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation after death completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one Signature and title of certific 2 29b. 29d. Date signed (Month Day, Year) death (Item 23a) (Type, Print) 10+1 fee 31. Date filed (Monti

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The state of the	Mary	2 should th and M 7 is ma traumat		19a. Informant's Name/Relationship (Type, Print)						Zip Code)
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23a. Part 1. Effort fer disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Ph. 1 and Medical Examining Ph. 2 and Medical Examining Ph. 3 and Medical Examining Ph. 4 and Medical Examining Ph. 4 and Medical Examining Ph. 4 and Medical Examining Ph. 5 and Medical Examining Ph. 6 and Medical Examining Ph. 7 and Medical Examining Ph. 8 and Medical Examining Ph. 9 and Medic	Itim	it. Page rtment rtant: I		4 ☐ Donation 5 ☐ Other (Specify)					-	
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		To the within: To the comple	Ž		pest of my knowledge	29c. Licens	e number			

ws of person who completed cause of death (Item 23a) (Type, Print)

M. Wieland MD 40 P.R.M.C. 100 F. Carroll St. Salisbury, MD 21822

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 2012 14 6:58 AM Lucille Reynolds Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 39160 Guy Family Way Mechanics ville Mary's County 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) **Funeral** Hours 90 Yrs. **Director** 579-18-2190 1 M 2 X F 08/04/1921 Culpepper, VA Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 ☐ Yes 2X No MD St. Mary's Mechanicsville ō 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 39160 Guy Family Way 20659 USA items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. White "natural", 3 X Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home 5th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ressie Unknown other traumatic John Thomas Frazier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 st it of Health a If item 27 is Donna Hill / Daughter P.O. BOX 495, Mechanicsville, Maryland 20659 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If it any injury or conce. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Charles Memorial 05/18/2012 4 ☐ Donation 5 ☐ Other (Specify) Leonardtown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. ₩- #M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1 (the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ cardiomyopath disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician a burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 W No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ths? Year Month Day Pregnant at time of death the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 5 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Was autopsy performed? 24a Was an this certificate has page 2 \square No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work of Funeral Director: As letely filled in by the funeral price of the filled in by the funeral filled in the funeral fille 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 71807 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5) eme Sarch A. Johnson 40900 merchants un 207 Leonardtwn, mo

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Russell Jewell Ivey Marth Day 201 gar 6. 10:30A. M Medical acility Name (if not institution, give street and number) City, Jown, or Location of Death Silver Spring Examiner 1209 Crestraven Drive Montgomery Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign **Funeral** Days Mississippi Hours 1 □ M 2 🏋 F 427-32-1667 Dec. 4.1923 88 Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director Maryland Montgomery Silver Spring 1 🗆 Yes 2 🗗 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20903 United States 1209 Cresthaven Drive 'natural", or items 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔼 No 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1₁4 or 5+) Clerk Typist U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lena Powell Lloyd Ivey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Heath a Important: If item 27 is any injury or other tra 1209 Cresthaven Drive Silver Spring, Maryland 20903 Dallas B. Bussell, Jr. -son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemeter, crematory or other place)
George Washington Cem. 5/9/2012 1 X Burial 2 ☐ Cremation 3, ☐ Removal from State Adelphi, Maryland 4 Donation 5 Other (Specify) 21. Signature of Function Service Licente Botald Vas Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, of shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Vears** Phonician/ Metastatic Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 1 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🖼 No Other: 1 Yes ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D70315 May 7, 2012 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rahul Y. Patel, M.D. 6000 Executive Blvd., #625 North Bethesda, Maryland 20852

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State Registrar 31. Date filed (Month, Day, Year)

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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Be	17. Father's Name (_	Nother's Name			n Surname)	
212 uld be Ments mark	To B	Michael 19a. Informant's Na				11	9b. Mailing	Address (St		ameka K			City or Town S	State, Zip Code)
MD rd 2 shoulth and m 27 is		Tameka K	. Evans/	mother									e, MD 2	
Te, land Heal	Ì	20a. Method of Disp			01-1-	20b. Place		ion (Name of			Date			ty or Town, State
Baltimore, permit. Pages 1 ar Department of Hee important: If ite			Cremation 3 Other Specify		om State			ematio	n St	7 05/	23/201	2 1	Hanover	r. MD
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Box 6876C ne death certificate the attending phys	₹ .	IF FEMALE: 23b. Was decedent p	pregnant in the	23c. If yes, o		f pregnanc						23	3d. Date of deli	
x 68 h certis ending use as	ciar	past 12 months?	?	1 Live b		e of death	- =	il death S er (Specify)	3 [E	ctopic pregnar	псу	- 1	Month	Day Year
Boy e death the att	Physician/M	1 Yes 2 ✔ N	o 9 Unknown	9 Unkno	wn		o Our	gi (Opecity)						
that the	by P	Part II. Other signifi	icant conditions	contributing to	death bu	t not resulti	ng in the un	derlying caus	e given	in Part I.		_	_	e to the cause of death?
Division of Vital Records, P.O. Box 6876. ral or Attending Physician: The law requires that the death certificate is alter death. 31 Director: After this certificate has been signed by the attending phyliced in by the funeral director, page 2 should be detached for use as the b	be												135-127	Probably 4 V Unknown
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Division of Vital Records, P.O. Box Within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atternopletely filled in by the funeral director, page 2 should be detached for u.	ल		Certifying Physici Medical Examiner	On the basis o	f examina					nd place, and o	due to the cau	se(s) ar	nd manner as s	
To Vii	Me	29b. Signature and ti	itle of certifier	and manner st	ated.		-	29c. Lice	nse nun	nber		29d.	Date signed (Month, Day, Year)
		PT	0 -	- Da01	0.0	~ .~		0.0	C.M.E.			Ma	y 14, 2012	
		30. Name and address	ss of person who	completed cause	e of death	(Item 23a)	-	<u> </u>				J	-	
			ica-Pollak MD						timore	Street, Ba	altimore, M	ID 212	223	
Sta Regista	ate ⁽ rar	31. Date filed (Month	7 1 8 2012	32 Reg	gistrar's Si	ignature	park							
	_			41		-								

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 7, Physician/ 2012 5:17 PM Heriberto Rodriguez Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery Social Security Number 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 580-72-0946 Director 75 1**X**□ M 2 □ F April 5, 1937 Puerto Rico Usual Residence of Deced Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No MD Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 410 Philadelphia Avenue 20912 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 K Married 3 3altimore, Maryland 21215-0036 1 K Yes 2 □ No Specify: Puerto Rican Specify White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Within Hygiene.

'ther than "r.

'the Me (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance System Operator Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Maximo Rodriguez Lopez Carme Maria de Jesus Rivera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Velia D. Rodriguez/Wife 410 Philadelphia Avenue, Takoma Park, MD 20912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 10. Department of H Important: If ite any injury or ot once, 1 X Burial 2 Cremation 3 Removal from State Maryland Nat'l Memorial Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 22. Name and Address of Facility rancis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each lir Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CARCINOMA SOPHAGEAL Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ng physician and e as the burial transit SFUNCTION MULTI ORGAN To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriallytansit. that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ANTERNY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural work?
1 Yes 2 No 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only or 29b. Signa 29d. Date signed (Month, Day, Year) Mmu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAMMIM, WASHINGTON ADVENTIST

Registrar

31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For AMEND# State Registrar	7+8+16ap	erFH	State 0 5/10/1	of Mary 2; Hw, N	/land / YbOb	Depa <i>Cer</i>	artmen <i>tificat</i> e	t of H e of L	ealth a Death	and M	ental Hy	/giené	20	12	1662	0
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	Funeral		5. Social Security I		6. Se:	x]M 2√27F	7. Age (In	n yrs. last b	irthday) Yrs.	If Under Months	Days	If Under	Min.	8. Date of Bi (Month, D	irth ay, Yaard	147	Cou	place (State or For ntry)	eign
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and	ontal to	Be.	17. Father's Name (First, Middle, Last) Salvatore Todero 18. Mother's Name (First, Middle, Last) Margaret Pote											0)					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20<u>12</u> Physician/ Month Thomas Sterling **Alvin** 3. 10:10 A. M May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Riverdale 4501 Oliver Street Prince Georges Social Security Number 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1926 1 X M 2 🗆 F Days Hours 218-75-7930 86 Jamaica, Indies **Director** January Usual Residence of Decedent show 10b. County filed within 72 hours after death with the Maryland at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a Maryland Prince Georges Riverdale 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20737 4501 Oliver Street Jamaica, West Indies 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc ò 1 Never Married 2 X Married þ 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black "natural". 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " ementary/Seconday (0-12) College (1-4 or 5+) Security Company Security Guard 8th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ADOPC,

Tit. Page 1 and 2 shu.

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Tem 27 is marked.

Traumatic ev. Mental I 2 Louise Dennis Sterling Assirah 19a Informant's Name/Relationship (Type, Brint) (Wite) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4501 Oliver Street; Riverdale, Maryland 20737 Sadie Elaine Phillips (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 21,2012 permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Beltsville, Maryland Chesapeake Crematory, Inc. 22. Name and Address of Facility R. N. Horton Company Morticians, uneral Servi Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events the attending physician and the dor use as the burial-transi Dehydration Due to (or as a consequence of) resulting in death) Last Physician/Medical Renal Failure Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 No Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Renal Insufficiency Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autonsy death? After this certificate 1 ☐ Yes 2 ☐ No the Funeral Director: After this certificableted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

24 hours a within 2 To the I

Registrar

Medical

29a. Certifier

(Check

only one 29b. Signature and title

Eveline Ane, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

7219 Hanover Parkway; Suite B

Greenbelt, Maryland 20770

29d. Date signed (Month, Day, Year, May 7, 2012

29c. License number

D64690

12-03519 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Donald E Sinkfield State of Maryland / Department of Health and Mental Hygiene 2012 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day May 6, 2012 **Medical Examiner** 1705 hrs DONALD Ε. SINKFIELD 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Laurel Regional Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Hours Director Country) 1 X M 2 F 78 09/13/1933 577-42-4375 DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Prince Georges **21215-0036** ould be filed within 72 hours after death with the Maryland Laurel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9010 Briarcroft Lane #422 20708 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 1X Yes ũ 4 Divorced If Yes, Give Year 1953 7955 3 X Widowed 1 Yes 2 X No specify: Black Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Letter Carrier US Postal Service 12th and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Tages 1 and 2 should be file then of Health and Mental Herast: If item 27 is marked of or other traumatic event, if Joseph Sinkfield Emma Sinkfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jena Sinkfield - Daughter 2603 Box Tree Dr. Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 5/12/2012 Donation 5 Other Specify Cedar Hill Cemetery Suitland, MD 21. Signature of Funeral Service Licensee Marshall-March" Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a, Hypertensive Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED attending physician or use as the burial of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ned by the detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 1 Yes 2 No 3 Probably 4 V Unknown Chronic Obstructive Pulmonary Disease; Obesity Completed icate has been si page 2 should b 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 No 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other: After this 1 Yes ဥ 28a. Date of Injury (Month, Day, Yeer) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 V Natural 1 Yes 2 No death Pending within 24 hours after death To the Funeral Director: the Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

To the Hospital
Within 24 hours
To the Funeral 1

Registrar

29b. Signature and title of certifier

Carol Allan, MD

Date filed (Manth, Day, Year

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Registrar's Signature

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 8, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH G927 5/31/2012 JH
State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3:00 a.m.[™] Schmidt 2012 Glynnis Erin May 16. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lexington Park St. Mary's 23146 Esperanza Drive If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 8. Date of Birth Social Security Number **Funeral** Days Hours 208-58-9619 Director 1 □ M 2 🛣 F Yrs 09/06/1974 Pennsylvania 37 Usual Residence of Decedent 28a-f show 10d. Inside City Limits at 10a, State 10b County 10c. City, Town or Location Director be notified 1 Tes 2 X No Maryland St. Mary's Lexington Park 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral injury or other traumatic event, the Medical Examiner must United States 23146 Esperanza Drive 20653 or items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than 2 should be filed within 7 h and Mental Hygiene.
7 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 4 Environmental Sanitarian Department of Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jane Ann Crozier Harbinson 2 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. William E. Starke Jane Ann Grezier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce W. Schmidt/Husband 23146 Esperanza Drive, Lexington Park, MD 20653 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State donation 5 Other (Specify)

Signature Ineral Strice to the Fdward N. Brinsis Brinsfield-Echols Cre 05/17/2012 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollwood Road. Leonardtown, MD 20650 22955 Hollywood Road, Leonardtown, MD N. Brinsfield 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. breast adenocarrinoma Metastatic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, in any, reading to infine duta cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the g Unknown Unknown Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has page 2 autopsy performe 2 🗌 No Yes 2 No 1 🗌 Yes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 16,2012 71807 auch A m - n10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40900 merchants in Ste 207 Lemanthum, ms Johnsm 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State MAY 1 7 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 - State of Mary State of Mary Registrar , TCHD, 5/8/2012, TLS Amended #1,#8 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SCHULTZ Physician/ JAMES FRANCIS MAY 2012 4:30 P M 3, SHULTZ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CHESTERTOWN NURSING AND REHAB KENT CHESTERTOWN M DARTY of BOTTR 1932 9. Birthplace (State or Foreign **Funeral** Hours 214-34-7327 79 BOZMAN, MD Director MARY 1932 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director or items 23a or 28a-f 1 X Yes 2 □ No MD KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 415 MORGNEC RD. 21620 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 X No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after Specify: WHITE 1 Yes 2 X No Specify. 'natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 CONTRACTOR HEATING & AIR CONDITION marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ LEO O. SCHULTZ MARGARET A. CALLAHAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau JEFFREY M. SCHULTZ / SON 5741 SW PASADENA DR. PORTLAND, OREGON 97219 Baltimore, 20a. Method of Disposition Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗌 Burial 2 🕱 Cremation 3 🗌 Removal from State CHESAPEAKENCREMATION 4 Donation 5 Other (Specify) 05/04/2012 CENTER STEVENSVILLE, MD 21. Signature of Furer Service FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON STREET EASTON, MARYLAND 21601 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications has shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Asmiration burn wall disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** e to lor se a kinsequative of Sequentially list conditions if any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events Exami requires that the death certificate be executed burial-transi Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Box 68760 nding p IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death
Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsv page perforn death? certificate | Yes or Attending Physician: æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending s after death.

I Director: Af
d in by the fu 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) filled i within 24 hours a

To the Funeral D

completed filled Hospital Medical 29a. Certifier Decritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) 52 f15000 TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Dep	eartment of Health and Nartificate of Death		21117	16625
		Registrar 1. Decedent's Name (First, Middle, Last)	runoate of Boats	Reg. 2. Date of Death	. No.	3. Time of Death
Physici		James R. Simpson		Month May	7 2012 ear	1:31 A M
Med Exami		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
١		1911 Henry Road	Rockville		Montgomery	7
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) Countr	ace (State or Foreign
Director		579-14-7387		Dec. 26,	1924 Mich	igan
and show	5	10a. State 10b. County 10c. City, Town or L	ocation		10	d. Inside City Limits
Maryla 18a-f	ect	MD Montgomery Ro	ckville			1 🗌 Yes 2 ី No
a or 2	Funeral Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Countr	y?
n with	nerg	1911 Henry Road	20851		United Stat	
ite, INIALYIATIO ZIZIO-0000 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No WW II If Yes, Give Year or Dates,	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, et Specify: Whi	c.
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ary and Me mark			ling Address (Street and Number or Run		ty or Town, State, Zip Co	ode)
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of He of He rothe		20a. Method of Disposition 20b. Place of Disposition cemetery or	amatony or other place)		c. Location - City or Tow	n, State
Page Trent		1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State demetery, cr. 4 ☐ Donation 5 ☐ Other (Specify) Metropol	itan Crematory May 20	/ A.1	lexandria,	VA
Dalumore, permit. Page 1 and Department of Heali Important: If item any injury or other once.		21. Signature of Funeral Service were M01117	22. Name and Address of Facility PeVol Funeral Home Gaithersburg	, 10 East	Deer Park 1	Drive,
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
Physician	4	Immediate Cause (Final disease or condition Malignant Mela	noma			Onset and Death
Medica Examine	_	resulting in death) Due to (or as a consequence of):				
ZAGIIIIIC		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
B ₹0	Ē	cause. Enter Underlying Cause (Disease or linjury				
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To the Hospital or Attending Physician: The law requires that the death certificate be executed Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial Haasit	Physician/Medical Examiner	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	y Day Year
at the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	cause of death?
Signe	d by			1 🗆 Yes	2 No 3 Proba	ably 4 🏋 Unknown
requi	Completed			24a. Was an		sy findings available
VICAL MECOLOS, ysician: The law require: Is certificate has been sig	dwo			autopsy performe	ed? death?	pletion of cause of
an: Tl an: Tl tifical tor, pa	ا ه	25. Was case referred to medical	26. Place of Death (Chec	1 Yes 2 b	X 110 1 163 2	
VILA nysici nis cer direc	70 B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	ent 3 DOA Other: 4 Nursing H	ome 5 X Residenc	ce 6 Other (Specify)	
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DIVISION cal or Attendir s after death. al Director: After the fuller of	10	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	City or Town, S	et and Number or Rural I State)	Houte Number,
ne Hospit n 24 hour ne Funera	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or involved and the basis of examination and	estigation, in my opinion, death occurred a	at the time, date and p	place, and due to the caus	se(s) and manner stated.
To the Congression		29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, D	ay, Year)
104		1601	D37142		May 7, 2012	
		30. Name and oddress of person who completed cause of death (Item 23a) (Type Geoffrey Coleman, M.D., 1355 Piccar	d Drive, Suite 100	, Rockvil	le, MD 2085	0
St Regist	ate trar	31. Date filed (Month, Day, Year) MAY 08 2012 32. Registrar's Signature	who			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner 8. Date of Birth (Month, Day, Year) If Under If Under 24 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Hours Country 579-09-7708 99 Director 1 M 2 X F Washington, DC Dec.3,1912 28a-f show 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director Silver Spring Md. Montgomery 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö 23a Funeral USA 20906 #L-29 14514 Homecrest Road items death 1 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō ģ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify Specify: is marked other than "natural" Completed 3 ₩ Widowed 4 □ Divorced White Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) should be filed within and Mental Hygiene. American University Secretary Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Francis Joseph MacMaugh Maude Estelle Sweet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mary K. O'Melveny/Daughter 2022 Columbia Rd., NW #315, Wash., D.C. 20009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation Alexandria, Va. 5 Other (Specify) Metropolitan Crem. 5-8-2012 MO1315 22. Name and Address of Facility DeVol Funeral Home Ave., N.W., Washington, DC 20007 2222 Wisconsin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such Interval Between Onset and Death shock, or heart failure. List only one cau Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last ttending physician for use as the buria Physician/Medical Bax 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death the hed 9 Unknown signed by the Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performe certificate l 1 ☐ Yes 2 ☐ No 25. Was case referred to medical the Hospital or Attending Physician: 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 1 Yes မ Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be . Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ess of person who completed cause death (Item 23a) (Type, Print) 18101 Prince Philip Dr., Olney, Md. 20832 MAY 09 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registraramend 20-22 per hosp. g927 State Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FAITH 0845 STUR DIVANT NASIA Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** DRINCE GEORGES PRINCE GEORGES HOSPITAL CHEVERLY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Hours NONE Director 1 🗆 M 2 🗶 F MARYLAND 28a-f show 10b. County 10c, City, Town or Location at 10a, State Director must be notified HYATTSVILLE 1 🗙 Yes 2 🗌 No PRINCE GEORGE'S MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 20185 Funeral 23a USA items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11, Marital Status Examiner Armed Forces? ò 1 X Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72. It hand Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) - INFANT the NONE NONE NONE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) P SHAKIRA SAWYER STURDIVANT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sin Department of Health an Important: If item 27 is n any injury or other SAWYER-CONTINENTAL HYATTSVILLE, MD 20185 MOTHER 8944 THEE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
prince George's Hosp. 1 Burial 2 Cremation 3 Removal from State 3/15/12 Cheverly, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ryvette Smith (per DVR) Prince George's Hosp. Cheverly, Md. 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EXTREME PREMATURITY disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** SPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events -transit Exam death certificate be executed TULE BLEED OUT INTRAVENTRICULAR and Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical Box 68760 the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) the should be detached 9 Unknown P.O. | signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has 1 Yes 2 No Yes 2 Hospital or Attending Physician: 24 hours after death. filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my opicion, death occurred. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 28 89 menner 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month $20\overset{\text{Year}}{12}$ Physician/ May 3:55 A Dolores Elaine Van Tassel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles 113 Bland Drive Indian Head 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours Min. 1 M 2 X F MaryTand 92 Yrs 1919 Director 577-16-2228 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10b. County at 10a. State 10d. Inside City Limits Director Examiner must be notified 1 Yes 2X No Maryland Charles Indian Head 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a 113 Bland Drive 20640 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian Black, White, etc. ĕ þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: item 27 is marked other than "natural", other traumatic event, the Medical Exa Specify. 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental I 7 is marked of ည Harvey Cartwright Eva Slingerland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Karen Johnson/ Daughter Box 182 Marbury, Maryland 20658 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cem. <u>Arlinaton. Virginia</u> 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licensee 3035 Old Washington Rd. Waldorf, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final AIZHEIME Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to lor as a consequence of Exami the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.s. autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 7 ္ဝ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 Katural 5 Pendina Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier 🛏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 1703 Laflate MD 20646 0

Registrar

31. Date filed (Montl

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2012 Physician/ Month May Philip Trusso 6 6:20 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Friends Nursing Home Montgomery Sandy Spring If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 93 Director 122-07-8398 1X M 2 | F May 27, 1918 NY ir than "naturel", or items 23e or 28e-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11022 Burnley Terrace 20902 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 X Married Completed by 1 X Yes 2 No If Yes, Give Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates. WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene, Elementary/Secondary (0-12) College (1-4 or 5+) Regional Sales Manager Sales Be permit. Pege 1 and 2 should be file Department of Health and Mental H Importent: if item 27 is marked any injury or - - -17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Basilio Trusso Carmela DiPaolo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Jean Trusso/Wife 11022 Burnley Terrace, Silver Spring, MD 20902 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State May 2012 Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Mates 500 University Blvd. W., Silver Spring. MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosclerotic Cardiovascular Disease Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial. Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 🖾 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

Registrar DHMH 17 Rev 06-2011

State

29a. Certifier

only one

30 Name and add

Benjamin 31. Date filed (Month, Day, Year)

29b. Signature and the of certifier

3 Certifying Nurse Pr

Avrunin, MD

08 2012

s of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

May 7, 2012

ctitioner: To the best of any knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

18111 Prince Philip Drive, #209, Olney, MD 20832

D08381

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 May 9, 5:00 PM[™] Mona Lisa <u>Thompson</u> Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Garrett <u>144 Old Crellin Road</u> Oakland 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country MD Hours Jul 22. **Director** 215-58-6379 60 28a-f show 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Garrett Oakland 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21550 144 Old Crellin Road USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 Ϊ No should be filed within 72 hours afte n and Mental Hygiene. 7 is marked other than "natural", If Yes, Give Year or Dates. Completed 3 Widowed 4 X Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) disabled n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pearl Anna Pifer William Albert Cottrill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21502 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau Lisa Cottrill daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Sunset Memorial Park 5/16/2013 MD on 5 Other Specify) Cumberland 22. Name and Address of Facility
Scarpelli Funeral Home, PA Sonature of uneral Service 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused shock, of heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ UNG disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** KU1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami Ichetes and-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🗌 No Yes 2 N 1 Yes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ٩ 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence this funeral of Certificate: 27. Manner of Death nours after death. neral Director; After that filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined To the Hospital within 24 hours a To the Funeral Completed filled Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed vause of death (Item 23a) (Type, Print) F. Manger M.D. 11600 Bedford

DHMH 17 Rev 7/2009

State

Registrar

MAY 2 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dorothy Maxwell Vassos May 5:55 pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Prince George's Renaissance Gardens - Riderwood Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 245-14-7362 Director 1 M 2 M F 10/22/1922 North Carolina Usual Residence of Decedent 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Silver Spring Maryland 1 Yes 2 No Montgomery ò 10f. Zip Code 10g. Citizen of What Country? ms 23a omnust be 3124 Gracefield Road. #213 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or iter dical Examiner Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Specify White Year or Dates Medical Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. the Telephone Operator Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ George Washington Maxwell Molly Stroupe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.v</u> Health tem 27 21213 Chrisman Hill Terrace, Boyds, Maryland 20841 Steven Vassos - Son 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 05/08/2012 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the dishock, or heart failu or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest st only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac Arrhythmia disease or condition Medical resulting in death) Examiner Atherosclerotic Cardiovascular Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and Due to (or as a consequence of): Physician/Medical use as the bur requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 X No 3 Ectopic pregnancy Month 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Chronic Obstructive Pulmonary Disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🌡 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No within 24 hours affer death.

To the Funeral Director: After this certificate the completely filled in his has former. 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident filled in by the Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 X Contribute Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check actitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse 29b. Signature and title of ertifie 29c. License number 29d. Date signed (Month, Day, Year) 12 D24035 May 07, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugenio S. Machado, M.D., 3110 Gracefield Road, Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year)

State

Registrar

MAY 08 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 Year Geon*a*e Wast Medical 2017 4a. Facility Name (if pot institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of MARYLAND MEDICAL CENTER BAITIMORE maryland Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Hours 213-36-7144 1 X M 2 □ F **Director** 72 Maryland Nov.16, 1939 with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code must be n 10g. Citizen of What Country? Funeral 21703 5656 Sandy Court USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. ö 1 X Yes 2 No 1958— If Yes, Give Year or Dates. 1961 þ 1 Never Married 2 Married be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural" Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Owner & Operator Oil Company raumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ George E. Suck Caroline Kolb 19a. Informant's Name/Relationship (Type, Print) Department of Health ar. Important: If item 27 is a any injury or other traumonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara West / Wife 5656 Sandy Court, Frederick, MD 21703 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State Mt. Olivet Cemetery 5/10/2012 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland Sign or of Funeral Service Licer Stauffer Funeral Home 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 Read I. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Due to (or 's a consequence of): disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) 1 Yes 2 No been signed by the a should be detached 1 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Director: After this certificate 1 Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospita 1 ☐ Yes 2 ☑ No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending Natural injury work? 1 ☐ Yes 2 ☐ No hours after death. ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a

To the Funeral I

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 1871892240 05/05/2012

12+1

Registrar

DHMH 17 Rev 06-2011

State

Baltimore, mo

21201

Greene

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Williams

Date filed (Mon.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 1:15 P M JOAN WILLS MAY 6, 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner APEX NURSING HOME SILVER SPRING MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 🖫 F Director 063-34-8508 1928 83 MAY 14, GUYANA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 1X Yes 2 No Director MD. MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2700 BARKER Funeral 20910 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No þ Specify: 3 Widowed 4 Divorced BLACK "natural" Completed I sharked other than "nature is marked other than "nature is marked other than "nature is madical is a second in the interest in the interest is not in the interest in the in 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSE NURSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P CLAUDE WALCOTT DOROTHY DEANE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is any injury or other trauonce. CLAUDE WALCOTT/BROTHER 17506 ST. THERESA DR., OLNEY, MD. 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 5-8-2012 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician Unknown disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Unknown if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of): physician a the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page hro me isease. 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death. Peral Director: A filled in by the for 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

State Registrar

within 24 hours a

To the Funeral I

completely filled

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ted cause of death (Item 23a) (Type, Print)

CHOWDHURY, MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

605 MAIN STREET, LAUREL, MD 20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16634 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WHITE Physician/ 33PM Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Nov 10, 1941 218-36-1650 Days West Virginia Director 1 M 2 □ F 70 Usual Residence of Deceder permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28e-f show eny Injury or other treumatic event, the Medical Evaration must be notified at 10a. State 10b County 10c. City, Town or Location 10d Inside City Limits Director Marriottsville 1 Yes 2 No Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 21104 7711 Stoney Ridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ty☐ Yes 2 ☐ No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) State of Maryland Trooper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wilma Cassell Brooks Walter White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2640 Thornbrook Road Ellicott City, MD 21042 Julia Ann Brittingham/sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗆 Burial 2 🗗 Cremation 3 🗀 Removal from State Ardent Cremation Svc. 5/10/2012 4 ☐ Donation 5 ☐ Other (Specify) Hanover, Maryland 21. Sign are of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. sanita Homa 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ypoxia Medical r as a consequence of: Fibrosis Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the funeral director. Cause (Disease or injury resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 - Pending work? 1 ☐ Yes 2 ☐ No Investigation ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certified RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1+ 1800 ORLEANS ST BALTIMORE MD 21287 JoneThan

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physici edical Exami		Decedent's Name (First, Middle,Last) CHARLES HAMILTON	WOODW	ARD I	I	1	2. Date of Dear Month May 9, 20	th Dav Y	ear	3. Time o		
		4a. Facility Name (if not institution, give street and number) Civista Medical Center	4	b. City, Tow LaPlata	n, or Locati	ion of Death		4c. Count Charle		th		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Ia 578-82-0435 1 X M 2 F 39		If Under 1		Jnder 24Hrs. ours Min.	1	h(MM/DD/YY)	Forei	gn ountry)	ate or	
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imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental lant; If item 27 is marked or other traumatic event,	ဥ	i sa. Informant's Name/Relationship (Type, Print) JAMES A. NASELLA/STEP-FATHE 20a. Method of Disposition 20b. P	19b. Mailing ER 153	30 PC	TOMA	C RIV	ER DR	bei, City or To COBE 20c. Location	IS	LAND	, MD	
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and IN Important: If item 27 is us injury or other traumatic		X Build: 2 Oromation o Nomoval Irom otate	RIST CI	H.CEM	ETER	Y 16,	2012		IDE	, MA	RYLAN	
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		Suicide 4 Homicide determined (Specify) 29a. Certifier (Check only (Check only (Specify))	e, death occurre	ed at the tim	e, date and	place, and du	or Town, St	ate) e(s) and manne	er as state	ed.		
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination an and manner stated. 29b. Signature and title of certifier	d/or investigatio	29c. Li	ense numb		ne time, date a	29d. Date sign	ned (Moi		ar)	
		30. Name and address of person who completed cause of death (Item 2 Ana Rubio MD. Assistant Medical Examiner 96				nore, MD :	21223		-14			
St Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signatur	e are					<u> </u>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland / Dep		Mental Hyg	iene 2012	10000					
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	2. Date of Deat	teg. No. 2012						
	Physicia Medi		Ira Mae Young		05/02/2		3. Time of Death 2:55 A M					
-	Examir		4a. Facility Name (if not institution, give street and number) 4116 Suitland Rd. #C	4b. City, Town, or Location of Death Suitland		orges						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	9. Birthr	place (State or Foreign					
	Director		579-18-0398 Usual Residence of Decedent 1 □ M 2 🕮 F 96 Yrs.		July 2,		AL					
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			ing Address (Street and Number or Rura Loma Secca San		City or Town, State, Zip C	ode)					
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Ba	Depar Impor any ir	Å	21. Signature of Funeral Service Licensee 2	2. Name and Address of Facility Mar 308 Suitland Road	shall-Ma	rch Funeral	Home					
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Division of Vital Records,	by School	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural F	Route Number,					
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	N VIII	1	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Da						
	10	}	30. Name and address of person who completed cause of death (Item 23a) (Type, F			2/04/1-4						
	Ψ'		Wasseem Hussain, MD 8116 Good Luck	Rd. #300 Lanham,	MD 20706	5						
	Stat Registra	- X	31. Date filed (Month, Day, Year) 32. Registrar's Signature	-								
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2012 Month Chester C. Yoakum May Medical 12:13 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9925 El Dee Drive Ellicott City Howard . Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Director** 452-38-2082 1**X** M 2 □ F 89 03/27/1923 WV Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at Director 10d. Inside City Limits MD Howard Ellicott City 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 9925 El Dee Drive 21042 United States Page 1 and 2 should be filed within 72 hours after death . Was Decedent Ever in U.S. Armed Forces?
1 ♣Yes 2 □ No If Yes, Give Year or Dates. 3. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian ō þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", 3 Divorced 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Engineer NSA 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John F. Yoakum Nora Talbott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Lillie Yoakum - Wife 9925 El Dee Drive Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkins Memorial Gar. 05/12/2012 Elkins, WV 21. Sig at re of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Thomas uanita 4112 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ Myclonus Onset and Death MUHIPLE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 10 31 6 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical I or Attending Physician: The law requires that the death certificate be after death.

Director: After this certificate has been signed by the attending physicia Box 68760 as IF FEMALE: outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) gned by the atter in the past 12 months? Pregnant at time of death Month Dav Year 9 Unknown Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by After this certificate has been si funeral director, page 2 should 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending (Month, Day, Year) Accident 1 🗌 Yes Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) MES D38500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

12+

egistrar's Signature

10710 Charter Drive Suite G020 Columbia, MD 21044

Nicholas W. Koutrelakos, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

atricia Sue Arr	nes	Single State Registrar	tate of Maryland		irtment o <i>tificate o</i>		nd Menta	ai Hyg		g. No.	201	2 16	63
Physici Medical Exami		1. Decedent's Name (First, Midd Patricia	lle,Last) Sue Armes			* 7		- 1	Date of Death	Day	Year	3. Time of Death	1
Y		4a. Facility Name (if not institution	on, give street and number)		4b. City, Town, o	r Location of		April 29, 20		unty of Deat		
, '		730 N. Essex Avenue		- (1 1-		Baltimore	. Den .	ogia. I	Baltimore County Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (Sta				
Funeral Director		5. Social Security Number 216–76–6878	6. Sex 7. Ag	50	ast birthday) Yrs	If Under 1 Ye. Months Day		Min.	11/5	/61	Forei	an .	1D
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Local	ion						10d. Inside City	Limits
faryland 28a-f show Latouce	JO.	MD	N/A			O	verlea					1 X Yes 2	No
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho mastic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 5801 Lillyan	Avenue, Apt	В		10f. Zip Code	21206		10	g. Citizen	of What Cou USA	•	
eath wit items 2	Funeral	11. Marital Status 1 Never Married 2 M	12. Was Decedent	?		as Decedent of H es, specify Cuba					Race - Amer White, etc.	ican Indian, Black	3
after de	by Fu	3 Widowed 4 Div	orced If Yes, Give Yeer or Dates:	XX No	1	Yes 2 XX No	o specify:			Spe	ecify:	White	ž
hours natur		15. Decedent's Education (Spe Elementary/Secondary (0-12)	cify only highest grade cor			nt's Usual Occupa ost of working life				16b. Kind	of Business	Industry	
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	7	0	J.)	V	larehous	e Work	er		M	anufac	nufacturing	
21215-0036 21215-0036 Judy be filed within 7 I Mental Hygiene. I marked other than ic event, the Medica	Be Co	17. Father's Name (First, Middle John Arme:	S		18.Mother's		irst, Middle, M tricia						
nore, MD 27 sges 1 and 2 should nt of Health and Me :: If item 27 is ma other traumatic er	Pa. Informant's Name/Relationship (Type, Print) Barbara Marie Arrowood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 730 Essex Avenue, Essex MD 21221										221		
Baltimore, MC permit. Pages I and 2 s Department of Health as Important: If item 27 injury or other traum.		20a. Method of Disposition 1 Burial 2 XX emation 4 Donation 5 Other S	pecify:	rematory or ot Ardent	Cremato	ry	5/5,	/2012	Han	over 1	Town, State Maryland		
Baltimo permit. Page Department of Important: injury or ott		21. Signature of Funeral Service	Licensee Victor	P. Do		lame and Addres Darles L 501 East	Steven	ens]	Funera	l Hom	e, Ind	21230	
Physician		23a. Part I. Enter the disease, or failure. List only one cause		the death.								Approximate In 8etween Onse	
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Methadone Due to (or as a cons			on						Death	~==
	١	Sequentially list conditions,	b									<u> </u>	
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876C tificate ng phys	Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor	me of pregn		tal death 3	Ectopic p	regnancy	,	23d. Da Mor	ate of deliver	y Day Yea	ır
Box 6876(c) death certificate the attending physel for use as the b	ပ	4 Pregnant at time of death 5 Other (Specify)											
that the dended by the	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to										contribute to	the cause of deat	h?
Division of Vital Records, P.O Ital or Attending Physician: The law requires that tr after death. In Director: After this certificate has been signed by left in by the funeral director, page 2 should be deared.	od be								1 Yes	2 No	3 Pro	oably 4 🗹 Unkn	own
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Vital Rec ysician: The his certificate director, page		25. Was case referred to medica				26 Place	e of Death (C	hook only	1 ✓ Yes 2		1 🗸 Y	es 2 N	No
Vital bysician	o Be	examiner?	Hospital: 1 Inpatie	ent 2	ER/Outpatient		Othor	Nursing H		Residence	6 🗸 Othe	r: Scene	
1 of Jing Ph. After the	- H	27. Manner of Death 1 Natural 5 Pend	28a. Date of Inju (Month, Day,Y	ıry 'ear)	28b. Time of I		ury at Work?		d. Describe h	ow injury o	ccurred		
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Div pital or cours aft meral Di	Certification	4 Homicide dete	d not be rmined (Specify)			ily Home	0.		or Town, Sta 11timor	ate)730	N. Es	sex Ave.	
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the temporary.	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
FXFX	ž	29b. Signature and title of certifie				29c. Licens		_				nth, Day, Year)	
		Carol M	allain	logth (li-	220)	0.C.	M.E.			April 30), 2012 ————		
		30. Name and address of person Carol Allan, MD As	sistant Medical Exar		•	imore Street	, Baltimore	e, M D 2	21223				
St Regist		31. Date filed (Month, Day, Year)	32. Registra	r's Signatur	back	,							
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 26. Physician/ 2012 Anderson James Walter 4:00A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2104 Suburban Greens Drive Timonium Baltimore 8. Date of Birth 0ct. 22, 1925 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday, 9. Birthplace (State or Foreign Days Hours Months 1 X M 2 □ F Baltimore Director 86 220-14-8160 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 ☐ Yes 2X No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be Funeral 23a 21093 2104 Suburban Greens Drive USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1

Yes 2 □ No Black. White, etc. ò Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Specify: White 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Trucking Contractor Mental Hygier Self Employeed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) F Health and Mental Hitem 27 is marked of other traumatic ever ပ Howard Anderson Bertha Eva Walter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 Suburban Greens Drive Timonium, MD 21093 Marguerite A. Anderson/Wife item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dufaney Valley Memorial Gardens ¥ Burial 2 ☐ Cremation 3 ☐ Removal from State 2012 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility emmon Funeral Home of Dulaney 10 W. Padonia Road Timonium, 21. Signature of Fuperal Sep 23a. Part 1. Enter the disease, or complications that only one cause or used the death. Do not enter the mode of dying, such Immediate Cause (Final Ph_sician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease of inique) that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Yes 2 No ed by the a detached t Unknown Unknown signed by t Other significant conditions contributed to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed page 2 should peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 Yes 2 No Yes in 24 hours after death. the Funeral Director. After this certifican pleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Yes No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: Describe how injury occurred the Hospital or Attending injury Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

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2 Medical Examiner: On the basis of 3 Certifying Nurse Practioner: To the

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 11:35 AM David W. Attebery May 22, Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth g. Birthplace (State or Foreign (Month, Day, Year) Hours Director 438-62-2484 1 🛛 M 2 □ F Yrs. March 9, 1942 Illinois 70 Usual Residence of Decedent 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 X Yes 2 □ No Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 102 Virginia Avenue United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Specify: Completed Year or Dates. 1966-1995 White item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Defense Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ David G. Attebery Ruth Wigk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 i Susan A. Nicholas / Daughter 8709 Heather Ridge Court, Gaithersburg, Maryland 20879 20a. Method of Disposition
1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ₽ Department o Important: If any injury or 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. May 26, 2012 | Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville THE WARN 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 60 shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Failure disease or condition resulting in death) Renal Vegr Medical Due to (or as a consequence of): Examiner perKalemia unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Cardiac hour and the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical David as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? been signed by the atte should be detached for Day Year 2 No 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autop-performed: death? after death.

Director: After this certificate! 1 Yes 2 Wo 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending iniury Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2gd. Date signed (Month, Day, Year) May 22, 2012 LOTI ne and address of person who comple ed cause of death (Item 23a) (Type, Print) Medical Center Drive Rockville, MD 20850 Joel 9901

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death Physician/ Month 3:52 HNDRESEN Medical **Examiner** Town, or Location of Death 4c. County of Death 4b. City NNEAR 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 M F Months Min nth, Day, Director 020-12-147 Heual Residence of De or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No ANNE HRUNDE ems 23a or r must be n 10e. Street and Number 10f. Zip C 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 2 No Ves Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Completed ハイモ RUTH MARY ANDRESER 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) and Mental F Department of Heath and Mente Important if item 27 is marked any injury or other traumatin conce. ပ TENNYSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Çity or Town, State, Zip Code) RAIPH ANDRESEN 337 OVERCE 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Sign V FUNERAL HOME 23a. Part 1. Enter the discase, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): -transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death Unknown the detached 9 Unknown P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagr 2 🗆 No 1 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medica To Be 26. Place of Death (Check only one) examiner? ASSISTED Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpa 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Dhawan 006253 0/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elli wit Chy Cheviolet DHAWAN, MUD 9055

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4:48 P Physician/ Ma^{₩onth} 22 Day 2012 Frederick William Becker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death
Montgomery 01ny Montgomery General Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days 95 100-03-7953 Director 1**X**M 2 □ F 08/28/1916 NY filed within 72 hours are...tal Hygiene.
ed other than "natural", or items 23a or 28a-f show
ed other than "natural", or items 23a or 28a-f show
e out, the Medical Examiner must be notified at 10c. City, Town or Location
Silver Spring 10a. State 10d. Inside City Limits Director MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20906 Pennfield Cir. #412 14800 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Was Decedent Ever III U.S. Armed Forces? 1 Ayes 2 □ No If Yes, Give Year or Dates. Black White etc 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) US Dept. of Justice Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be filed. Health and Mental Health and Mental Health and Mental Hem 27 is marked ot Anna Arpen Henry C. Becker 19a. Informant's Name/Relationship (Type, Print)
Marian Becker/Wife 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cada) 20906 permit. Pals.
Department of he.
Important: If item 27
"ny injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May Day 4, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. Beltsville, MD Inc 2012 . Signature of Funeral Service Licenses 22. Name and Address of FacilRapp Funeral & Cremation Services Rebocca 401585 spersime 933 Gist Ave. Silver Spring, MD 20910 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between 13 mset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 1 Hour Cardiopulmonary Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical death certificate be 68760 as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box (23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Prior Pneumonias aw requires Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 🛣 No or Attending Physician: **Division of Vital** 26. Place of Death (Check only one) Be 2 X No 1 Inpatient 2 KER/Outpatient 3 IDOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined e Funeral (Medical 29a. Certifier 1 💒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signatur 29c. License number 05/22/2012 D36282 who completed cause of death (Item 23a) Type, Print) ya, 10605 Concord St. #500 Kensington, MD 20895 30. Name and address of person who con Steven T. Kariya, 14 31. Date filed (Month, Day, Year) 32. Registrar's bignatur State

DHMH 17 Rev 06-201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Wesley A. Brown Physician/ MO05/22/2012 11:35P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Spring House Assisted Montgomery Living Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 129-26-4517 Director 1 🗙 M 2 🗆 F 85 04/3/1927 Yrs MD Usual Residence of Dece or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 2201 Colston Dr. #511 20910 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ 2 No Maryland 21215-0036 1949-1969 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) 72 1 Give kind of work done during most of working filed within 72 tal Hygiene. life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **5** Naval Officer Military event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ပ Rosetta Brown Harris William Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willetta B. West - Daughter 204 Clarion Ave. Elkins Park PA 19027 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory | 05/25/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 933 Gist Ave20910 401585 Melbecc Rapp Funeral & Cremation Ser. Acke Silver Spring MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Metastic Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exam Physician: The law requires that the death certificate be executed and -trar J physician and street purial-t Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed death? this certificate 1 Yes 2 No Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 M Other (Specify funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? within 24 hours arter described in 24 hours arter to the Funeral Director. After the funer that is by the funer that is a second of the funer to the Certificate: 28d. Describe how injury occurred To the Hospital or Attending 🔀 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical

State

Registrar

DHMH 17 Rev 06-2011

29a. Certifier (Check

29b. Signature and title of certifier

31. Date filed (Month, Day

JOCELUINE

Jocelyne T. Kouatchou

9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

05/24/2012

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

4041 Powder Mill Rd. Calverton MD 20705

amend #26 PegtaRHV f 6027 land 49 de 101 fm et of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY 16^{Day} 2012 12:40PM HELEN BASSFORD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD BEL AIR AUTUMN ASSISTED LIVING 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 T F OCT. 127 Year 1925 CA Director 86 573-24-2101 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at by Funeral Director MD HARFORD BEL AIR 1 ☐ Yes 2X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a USA 21014 1415 ST. FRANCIS RD permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. WHITE 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes. Give Specify: Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) INSURANCE SECRETARY Be 18 Mother's Name (First Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) STEVE AMBRUS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1453 VALLEY FORGE WAY ABINGDON, MD 21009 KEN BASSFORD-SON 20b. Place of Disposition (Name of cemetery, crematory or other place)
NATIONAL MEM. PARK 20a. Method of Disposition
1 ☑ Burje 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Date 5-25-2012 FALLS CHURCH, VA 4 Domation 5 Other (Specify) SCHIMUNEK FUNERAL HOME OF BELAIR e of Funeral Service Licensee Signaty 22. Name and Address of Facility 610 W. MACPHAIL RD BEL AIR, MD 21014 Rent 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ To Thrue disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Mospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical P.O. Box 68760 phys the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nursing Home 6 Other (Specify) Hospital: 2 No 읻 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Living 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The certifying involved in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) David 3 032279 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Dun GISW. MA= David 31. Date filed (Month, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Thomas James Bussey 1:55 PM Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** HOS Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 214-48-1204 65 **Director** 1 XM 2 □ F 06/09/1946 MD ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Halethorpe MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 USA 3006 Maryland Avenue 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify: 1965-68 Completed 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Drywall Estimator should be filed with and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 UNK Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra 3006 Maryland Ave Halethorpe MD 21227 Judy Schriner-Bussey Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 ament of h cemetery, crematory or other place) 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State 05/28/12 Glen Burnie MD Atlantic Crem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv 7090 Ridge Rd Hanover MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year 5 Other (specify) Month Day Pregnant at time of death signed by the at d be detached for Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes N cate has I; page 2 s certificate 2/No Ď 1 Yes Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No မှ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After injury Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) ma May HI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year,

MAY 2 9 2012

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please Type or I State of State Registrar		l / Depa		lealth and l	Mental Hygi		112 16641		
Physiciar Medic		1. Decedent's Name (First, Middle, Last) Teri Lee Brown					2. Date of Death Month 05/08/		Year 3. Time of Death 7:57 p M		
Examine		4a. Facility Name (if not institution, give street and numb Laurel Wood Nursing		4b. City, Town, or $f E$	Location of Death		4c. County of Death Cecil				
Funeral Director		5. Social Security Number 221-56-1706 6. Sex 1 Months Days Hours Min. 08/24/1959 9. Usual Residence of Decedent									
Maryland 28a-f show otified at	Director	10a. State MD Cecil		Town or Loc ton	eation				10d. Inside City Limits 1 ☐ Yes 2 🏝 No		
s 23a or 3	Funeral D	10e. Street and Number 100 Laurel Drive			10f. Zip Code 21	921	10	ng. Citizen of Wh	nat Country?		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmportant: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	β	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced 12. Was Deced Armed Forc 1 ☐ Yes 3 If Yes, Give Year or Dat	es? X No	"	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2X No	n, Mexican, Puerto	ecify Yes or No- o Rican, etc.)		- American Indian, , White, etc. White		
ithin 72 hour ene. than "natul he Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4)	or 5+)	(Give F life. D	ent's Usual Occupions of work done of NOT use retired) memaker	16b. Kind of Bus	siness Industry maker				
d be filed w Mental Hygi arked other atic event, t	To Be	17. Father's Name (First, Middle, Last) Herbert Robert Popkey	,				ne (First, Middle, M ean Dav				
d 2 should alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Lori Squier Sister		19b. Mailin 505	g Address (Street a Briar L	and Number or Ru ane New	ral Route Number, (ark DE	City or Town Ste 19711	ate, Zip Code)		
Page 1 an ment of He ant: If iterr ury or othe		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from 5 4 □ Donation 5 □ Other (Specify)	state cer	metery, crem Lanti	sition (Name of natory or other place C Crem	05/	12/12	Glen B	City or Town, State		
permit. Depart Import any inj		21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that ca		Т	homasAl	lenPA 7	090 Rid	ge Rd	& Fun Serv Hanover MD		
urisiar e	dical Examiner										
e death certifica the attending p thed for use as t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown							e of delivery th Day Year		
uires that th signed by Id be detac	by	Part II. Other significant conditions contributing to de	ath but not resul	lting in the u	nderlying cause giv	ven in Part I.	2001210100		bute to the cause of death? 3 □ Probably 4 및 Unknown		
The law requate has beer page 2 shou	Completed						24a. Was ar autops perforn 1 \(\sum \text{Yes}\) 2	y pr	lere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☐ No		
ysician: nis certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	npatient 2 🗆 E	ER/Outpatier	_ Oth	ace of Death (Che er: 4 Nursing I	ck only one) Iome 5 🗆 Reside	nce 6 🗆 Other	: (Specify)		
Attending Pl death. ctor: After thy y the funeral		2 Accident Investigation	n, Day, Year)	28b. Time of injury	work	y at ? Yes 2 □ No	28d. Describe hor		d r or Rural Route Number,		
lospital or all the control of the c	Medical Certificate:	29a. Certifier (Check 2 Medical Examiner: On the basis	of examination	and/or inves	tigation, in my opinio	on, death occurred	at the time, date and	e(s) and manner	to the cause(s) and manner stated		
To the I	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo									
31		30. Name and address of person who completed cause Dr M Sachdev 322 Eas				Fact M	D 21901				
Stat Registra			gistrar's Signatu)	шазс М					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month ARON BUBIS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NDSPITAL of Beltimore N/A Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 136-72-2563 Director 1**XX**M 2 □ F 102 UKRAINE 110/18/1909 Usual Residence of Deceden or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD N/A BALTIMORE 1XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5900 PARK HEIGHTS AVENUE, #304 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 XNo Specify WHITE 3 X Widowed 4 □ Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. is marked other tha **ENGINEER** MACHINERY Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. ပ ABRAM BUBIS GUSTA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIKTOR BUBIS/SON 3440 ASSOCIATED WAY, #114 OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State HAR SINAI CEMETERY 05/25/2012 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MD 21. Signature uneral Service Lice SOL LEVINSON & BROS., 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ panctretic Metaltetic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 16 days situation 1114VY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 18 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 5 Pending Natural 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PES May 25, 2012 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CINNPR PAVE MD SINAL NOTITE!

Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day, Year)

MAY 2 9 2012

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32. Registrar's Signature

of Baltimore, 2001 W. Belledere ALR Biltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 201 Sarah M. Cooper Medical Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Haspital Bon Secours Baltimone 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min 1 M 2 M Director Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Director altimore 28a-f 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be n Funeral Edgewood Department of Health and Mental Hygiene. Important: If item 27 is marked other than "marriage any injury or other traumatic mone. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Giver kind of work done during most of working life DO NOT use retired) ary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) er's Name (First, M<u>id</u>dle, Maiden Surname, ೭ nao forma ame/Relationsh Stanl homesina 20a. Method of Disposition Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funda Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or healt-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Mylcardial disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be after death. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year detached the 1 ☐ Yes 2 ☐ 9 ☐ Unknown this certificate has been signed by ral director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Vunknown Were autopsy findings available prior to completion of cause of death? 24a Was an perform 2 🗌 No 1 Yes 2 eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 2 1 No 1 🗆 Yes ER/Outpatient 3 DOA 1 Inpatient 2 5 Residence 6 Other (Specify, 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Do063565

State
Registrar

. Date filed (Month. Day.

MAY 2 9 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bon Secours Hospital Sherron Benn-Thompson, MD Zooo W. Baltimore St

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 3 per dr.,g927,05/29/2012dhb, 21

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 1640 **Physician** 2012 /Medical 4b. City, Town, or Location of Death 4c. County of Death give street and number) 4a. Facility Name (If not institution, Examiner Birthplace (State or Foreign
 Country) Date of Birth (Month, Day, 6. Sex (In vrs last hirthday Year **Funeral** 1 ▼ M 2 □ F Min. Months Davs Hours Hendricks 2.34.54.35/4 Usual Residence of Decedent Director 10d. Inside City Limits death with the Maryland 10b. County 10c. City. Town or Location 10a State 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ozark 262 ane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No or items, 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify. If Yes, Give Year or Dates: Specify: ģ 3 Widowed 4 Divorced "natural". Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, I'm Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Vanager 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number of Rul I Route Number, City or Town, Stark, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lane Hendri WU 2627 mozark Ann 275 June 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009. WV Cita 150NS 4 ☐ Donation 5 ☐ Other (Specify) 22. Name n Address of Facility 21. Signature of Funeral Service Licensee Fredlock per DWR Summer Field Parsons W626287 runeral Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) week **Physician** acerte Renal Lailua /Medical Due to (or as a consequence of): Examiner systolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed hroNic rena and the burial-tran Due to (or as a consequence of): attending physician for use as the burial Chronic Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 🗆 No 1 ☐ Yes 1 ☐ Yes 2 No Vital or Attending Physician: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2No 1 ☐ Yes 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this ō 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ay un 1266 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) oubland, UD 24550 awett mara 31. Date filed (A onth, Day, Year) State 2'9 2012 Registrar

12-03707
12-03/0/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Dominique C. Ca		bell S 1- For State Registrar	tate of Maryla		artment of <i>rtificate of</i>		Mental H	_	Reg. No.	20	12	1665
Physicia Medical Examin	n/	Decedent's Name (First, Middle Dominique Lowe)		7				2. Date of De Month May 14,	eath Day	Year		me of Death 334 hrs
1		4a. Facility Name (if not instituti Prince Georges Hosp	on, give street and nu	mber)		4b. City, Town, or L	ocation of Death		4c.	County of D		
Funeral Director		5. Social Security Number 215–88–0976	6. Sex	7. Age (In yrs.	last birthday) Yrs	If Under 1 Year Months Days	If Under 24Hrs Hours Min.	8. Date of E	Birth(MM/I	DD/YYYY) 9		
w any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locat	ion		100 10	- 137			Inside City Limits Yes 2 No
Maryland 28a-f show d at once	Director	DC 10e. Street and Number		Wash	ington	10f. Zip Code				en of What	-	THES 2 NO
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene. nat: If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.	Funeral Di	4337 4th St., 1 11. Marital Status 1 Never Married 2 X	12. Was Dec Armed Fo	2 X No		s Decedent of Hispa es, specify Cuban, I	Mexican, Puerto			14. Race - A White, e	tc.	dian, Black,
5 72 hours after a "natural", ral Examiner	<u>۾</u>	3 Widowed 4 Di 15. Decedent's Education (Spe Elementary/Secondary (0-12)	College (1	e completed) -4 or 5+)		Yes 2 No t's Usual Occupation ost of working life. I	n (Give kind of v			Specify: B 1		у
21215-0036 and be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Completed	17. Father's Name (First, Middle			Truck	18	3.Mother's Name	•	, Maiden	ivate Surname)		
D 2127 should be faming Mental is marke	To Be	Wendell Campbe	ship (Type, Print)	_		Address (Street		Rural Route Nu	umber, Cit	-		(ode)
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tinjury or other traumatic event, the Med	ŀ	Chante Campbe 20a. Method of Disposition 1 Burial 2 Crematio		om State	Place of Dispos crematory or oth		etery,	Date	20c. L	ocation - Ci	ty or Town,	State
Baltimore, permit. Pages I an Department of Hei Important. If ite injury or other tr		4 Donation 5 Other S 21. Signature of Funeral Service		male	22. N	Crematory ame and Address of 83 Middle	of FacilitiRona		lorI	[Fune	ral E	
Physician Modrat Examiner	4	23a. Part I. Enter the disease, o failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	nshot Wour	nds	ne mode of dying, si	uch as cardiac o	r respiratory a	rrest, sho	ck, or heart		proximate Interval tween Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a									
cuted	edical Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o	of):							
		UNPENDED IF FEMALE:	AMENDED 23c. If yes, of	outcome of preg	gnancy				23d	. Date of del	livery	
Box 68760, c death certificate be the attending physic ed for use as the burned.	Physician/M	23b. Was decedent pregnant in t past 12 months?	I Tive Di	ant at time of de	nath -	tal death 3 ner (Specify)	Ectopic pregna	ncy	ļ	Month	Day	Year
cords, P.O. B law requires that the d has been signed by the should be detached	۵	Part II. Other significant condi	tions contributing to	death but not r	esulting in the u	nderlying cause giv	en in Part I.	1Y	es 2 🗸	No 3	Probably	use of death? 4 Unknown
Rec The ficate	Completed	25. Was case referred to medical	si T			26 Place o	f Death (Check o	perf 1 ✓ Yes	s an opsy formed?	prior deat	to comple	findings available tion of cause of
of Vitaling Physician After this cert	ě	examiner? 1 ✓ Yes 2 No	Hospital: 1 l		ER/Outpatient	3 DOA	ther Nursin	g Home 5			Other:	=0,456
vision of an attending Phore death. Virector: After to a by the funeral			ding 28a. Date (Month) May 14,	of Injury Day Year) 2012	28b. Time of li 2242 hrs			28d. Describe Subject sh	ot by Ía	w enforce		
Division To the Hospital or Attend within 24 hours af er death To the Funeral Directors completely filled a by the	Certification:	4 Homicide dete	ermined (Specify)	Local Stre	et	et, factory, office bui	10	or Town, 4200 blk 6th	State) Street,	SE, Washi	ngton, DC	ute Number, City
To the Hos within 24 h	Medical	(Check only	thysician: To the best aminer:On the basis o and manner st	f examination a	-							e(s)
	Ĭ	29b. Signature and title of certifi	er		11	29c. License			1111111	15, 2012		ıy, Year)
		30. Name/and address of person Russell Alexander MD	D. Assistant M	edical Exan	niner 900	W. Baltimore S	treet, Baltim	ore, MD 2	1223			
Sta Registr	~	31. Date filed (Month, Day, Year) NAY 2 9 20	32. Re	gistrar's Signati	barke	,				OGME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May 2012 24 10:15 AM Mildred Mary Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care-Potomac Potomac Montgomery Social Security Number 8. Date of Birth (Month, Day Year) August 22, 1921 **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days Hours 222-09-0388 **Director** 90 Delaware Usual Residence of Decedent show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director ms 23a or 28a-f s must be notified Maryland Bethesda 1 ☐ Yes 2 🛣 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9604 Rockville Pike 20814 United States ural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian þ 1 Never Married 2 Married Black, White, etc. 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify: "natural", Completed 3 X Widowed 4 Divorced Specify: White Year or Dates it of Health and Mental Hygiene.

If item 27 is marked other than "natu or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Frank Turulski Elsie Ann Bojanowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Welsh Montovani/Daughter 9604 Rockville Pike, Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Jown, State Cockeysville, Department of H Important: If ite any injury or ot Dulaney Valley Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State May 4 ☐ Donation 5 ☐ Other (Specify) Ž012 Maryland permit. Signature of Funeral Service License 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. lette Daysis M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 14 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Esophageal Stricture disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events that initiated events.) Due to (or as a consequence of): Examir sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 Yes 2 No signed by the a g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed Debilitated 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 💢 No Hospital or Attending Physician: 1 24 hours after death. Funeral Director. After this certifics sted filled in by the funeral director. p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural Accident 5 Pending injury 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Funeral 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier pleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

homas

Thomas Masterson,

31. Date filed (M

MD50534

10714 Potomac Tennis Lane, Potomac, Maryland 20854

May 24, 2012

WO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ David L. Carnes, Sr. 2012 May 2:40p Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** n/a 1919 Griffis Avenue Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 XM 2 □ F Hours Months 219-30-5930 **Director** 1934 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at death with the Maryland Director Baltimore MD n/a 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 USA 1919 Griffis Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. by 1 Never Married 2 M Married Maryland 21215-0036 ier than "natural", c the Medical Exam If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mfg. Clerk 10 event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental F fitem 27 is marked of r other traumatic ever ပ Department of Health and Ment. Important: If item 27 is marked any injury or any injury or any injury or any Cora Griffin John Carnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1919 Griffis Avenue, Baltimore, Maryland 21230 Gertrude Honeycutt/ S.O. altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 5/29/2012 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Signature Tunera Son ic License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 NON SMALL CELL WNG CANCE Approximate Interval Between nset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ METASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of) YEAR **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Examin Cause (Disease or linjury that initiated events -tran and Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical certificate be Box 68760 the IF FEMALE: use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Day 5 Other (specify) Month Year Pregnant at time of death detached 1 the P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Yes 2 No certificate 1 Yes 2 No al or Attending Physician: after death. Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signati 30. Name and address of person who com SECURITY

State Registrar 31. Date filed (Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Deborah Ann Cro		1- For State	Sta	ate of Maryla			ent of		and I	Mental I	Hygiene		21		2	1665
Physicia	ا مر	Registrar 1. Decedent's Name	e (First, Middle	e.Last)			- Cor				2. Date of I	Reg. N eath	lo.		3. Time o	
Medical Examin	er	Deborah	n Ann	Crossle	-						Month May 7,	2012			0255	
1		4a. Facility Name (i Calvert Men			umber)		41	City, Town Prince Fr		cation of Dea ck	th		4c. County of Calvert	Death		
Funeral	7	5. Social Security N	lumber	6. Sex	7. Age (In yrs	Age (In yrs. last birthday) If Under 1 Year If			If Under 24H	rs. 8. Date of	Birth (M	M/DD/YYYY)			ate or	
Director		217-64-9	9109	1 M 2 F		54	Yrs.	Months E	Days	Hours Mi	n. 05/28/1957 Foreign Country) Wa			ashDC		
A .		Usual Residence of 10a. State	Decedent 10b. County		Inc. Ci	the Tower	or Locatio	nn .							10d Insid	e City Limits
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aryłan Sa-f si	Director	10e. Street and Nur	mber				Ť	10f. Zip Cod	е			10g. C	Citizen of Wha	t Coun	try?	
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eath with	era	11. Marital Status			cedent Ever in	U.S.	13. Was	Decedent of	Hispar	nic Origin? (S	Specify Yes or	No-	14. Race -		an Indian	Black,
r death	Funeral	1 Never Marrie		1 Yes	2 X No			es, specify Cuban, Mexican, Puerto Yes 2X No specify:			o radan, etc.,				White	
ural",	<u>a</u>	3 Widowed 15. Decedent's Ed		orced If Yes, Give Yea or Dates: ify only highest gra		16a.				(Give kind of	work done	Specify: work done 16b. Kind of Bus			dustry	
72 hours a "natur	ete -	Elementary/Seco		College (1	during mo	st of working		O NOT use re						
11215-0036 Id be filed within 72 hours after death with the Maryland fental Hygiene. narked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	Completed	12				H	omema	aker		***			Homem	ake	er	
filed v		17. Father's Name (18.1		ne (First, Midd		•			
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AD 2 shou 2 shou 27 is 1 mattic	-1			Moore S	ister						Clayt					
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MOI Pages sent of int: Il		1 Burial 2 Donation 5		3 Removal fr	om State			Cre	m	5/	22/12		Glen	Bur	nie	MD
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n injury or other traumatic event, the Medical E.	Į	21. Standille of Fur					22. Na	me and Addr	ess of	Facility Si	mplic	ity	Crem	. &	Fun	Serv
Physician	4	23a. Part I. Enter th	-	complications that of	aused the dea	th. Do n					090 R					MD nate Interval
/Medical		failure. List on! Immediate Cause (I	y one cause												Between	n Onset and Death
Examiner	1	or condition resulting		Due to (or as a	consequence	of):										
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V - 0 3 1	S S	past 12 months	?	4 Pregr	nant at time of α			I death er (Specify)	31	Ectopic pregr	апсу	Ì	Month	Da	ay	Year
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P. C. S. that s that a deta	2	Part II. Other signif	icant conditi	ons contributing to	o death but not	t resultin	g in the un	derlying caus	se give	n in Part I.			o use contrib	_		
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Reco	Completed		-									rformed	? de	ath? ✓ Yes		
inn: Jinn: Jenn: J	98	25. Was case referr examiner?	ed to medical							Death (Check						
Physic rathis cal dire	٥L	1 ✔ Yes 2	2 No		Inpatient 2						ing Home 5			Other:		
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isior Attend er death. rector:	E	2 Accident 3 Suicide	Inves	igation 28e Plac	e of Injury - At	home, fa	arm, street,				28f. Locatio	n (Street	t and Number	or Rura	al Route N	umber, City
Div	Certification:	Suicide 4 Homicide	deteri	not be (Specify)							or Town	, State)				22
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	0.0	Patricia Aror		IVID. ASSIST	ant Medica		iner 9	ou w. Ba	umoi	e Street, I	baitimore,	WID 21	1223			
Sta Registr	ie ar	31. Date filed (Mont	2012	Cenn	egistrat's Sign	TEL.										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0 Physician/ 4:19 AM ERIC, CAVES 1012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Baltimore Maryland Medical Centr If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Director 1 🗶 M 2 🗆 F 220-88-3260 35 10/14/1976 Maryland Usual Residence of Deceden or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2X No Stoney Beach MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or must be n ö Funeral U.S.A. 21226 7839 Creek Shore Way within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 5 1 Never Married 2 Married by 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Ith and Mental Hygiene.

27 is marked other than traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Tattoo 12 Tattoo Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 pe i Jeffords Sharen Darrell Caves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trauonce. Stoney Beach, MD 21226 7839 Creek Shore Way Mrs. Angelina Giardina / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 K Cremation 3 Removal from State 05/26/2012 Glen Burnie, MD Atlantic Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD 21. Signatur uneral S The Linesee Singleton Funeral & Cremation Services, PA Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Onset and Death Immediate Cause (Final Phylician/ disease or condition Medical resulting in death) Examiner dequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine igned by the attending physician and be detached for use as the burial-transit Marrow resulting in death) Last Physician/Medical Caemia To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

9 Unknown Month Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by Penallium 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown should Were autopsy findings available prior to completion of cause of 24a. Was an Kneum on ate has b autopsy perform death? 1 ☐ Yes 2 No After this certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 \(\text{Yes} \) 2 \(\text{No} \) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural iniury $5 \square$ Pending s after death. the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely only one, 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 29c. License number 2012 D69499 05,22, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENE SI, BALTIMORE. GANJI 22

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death $\mathop{\text{Mav}}^{\text{Month}}$ Physician/ 2012^{ea} 9:30 A. 16. William Gordon Cornett Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Middle River 89 Shawgo Court 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Hours Min April25,1949 406-68-2297 1X M 2 □ F Kentucky Director 63 Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 X No Middle River Maryland Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a Funeral U.S.A. 21220 89 Shawgo Court or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1. Marital Status Examiner Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 3 Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Year or Dates 1 and 2 should be filed within 72 hours of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Roofing Laborer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Hannah Earl Oscar Cornett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 89 Shawgo Court, Middle River, Maryland 21220 Marian Dorman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or or X Burial 2 \square Cremation 3 \square Removal from State 5-23-12 Baltimore, Maryland Oak Lawn Cemetery Donation 5 U Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee michael 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onsetland Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Exami and -trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tyes 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical/Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Dav, Year) 29b. Signature and tipe of c a 31237 person who completed cause of death (Item 23a) (Type, Print) 30. Name and addi BAHARIN VIEL STAUTING OILL 20 STE

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 6656 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sharon M. Dobie - Lewis Day Physician/ Month Year 3:05 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North West Hospital Randallstown MD Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, ocial Security Number 064–48–9190 **Funeral** Min Months Days Hours 56 12/28/55 Director 1 M 2XX NY permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 XXYes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 3805 Cedardale Rd 21215 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 5+Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Jesse Dobie Jimmy Nan Harshaw 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3805 Cedardale Rd Baltimore MD 21215 Leroy L. Lewis Husband Department of Health Important: If item 27 any injury or other the once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State The Evergreens Cem 5/25/12 Donation 5 Other (Specify) Brooklyn NY 22. Name and Address of Facility
CHarles L. Stevens Funeral Home,
1501 E. Fort Avenue, Baltimore M 21. Signa Funeral Service Lin Victor P. Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ 50H HISSUE CONCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Tonknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of ate has b autopsy performed Yes 2 death?

1 Yes 2 No 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Tother Specify 2 No 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 115/Wapamemo 0005746 5/17/12

DHMH 17 Rev 06-2011

State Registrar 5703

Smin M

Baltimore MD 21709

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

Rayapa KJEMO

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	Př	nysicia Medic		1. Decedent's Name (First, Middle, Beula)	h Do	US 19.	ک			2. Date of D	eath Jan	201/2	3. Time	of Death
9		xamin	er	4a. Facility Name (if not institution, g	est Hos	p. fal	_	Ra	has been of Delat	touh	B	enty of Dear	hose	
	Dir	neral ector		5. Social Security Number 219–38–4728 Usual Residence of Decedent	3. Sex 7. A(ge (In yrs. last t 87		f Under 1 Year Ionths Days	If Under 24 Hrs Hours Min.		ay, Year)	9. Bir Co	thplace (State untry) MS	_
	aryland	a-f show fied at	ector	10a. State 10b. County	Baltimore	10c. City, To	own or Locat Ranc	allstown	 	<u>- I </u>			1	City Limits
	vith the M	23a or 28 st be not	Funeral Director	10e. Stygtog Number 13803 Dovedale Co.	nrt.			10f. Zip Code 211	.33		10g. Citizen	of What Co		
950	should be filed within 72 hours after death with the Maryland and Mental Hygiene.	ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Marrie 3X Widowed 4 Divorced	12. Was Decedent Armed Forces?				ispanic Origin? (S an, Mexican, Puerl	pecify Yes or No to Rican, etc.)		Race - Ame Black, White	rican Indian, e, etc.	rican
נ	2 hour	edical	Completed	15. Decedent' (Specify only highest	's Education	16	(Give kind	t's Usual Occup of of work done of	ation during most of wo	rking	16b. Kind o	f Business/	Industry	
949	within giene.	the M	Con	Elementary/Secondary (0-12)	College (1-4 or	5+)	Jani	OT use retired)			Baltimo	re Cit	y School	ls
Mandand 21215,0036	should be filed within and Mental Hygiene.	is marked other aumatic event, th	To Be	17. Father's Name (First, Middle, Las Warren Dillon	st)				18. Mother's Na Muriel		e, Maiden Surna	ame)		
N	~ 된	tem 27 is marke other traumatic		19a. Informant's Name/Relationship Marion Douglas/ Dat		11	3803 3803	Address (Street a	and Number or Ru curt, Randa	iral Route Numb	er, City or Town	n, State, Zip	Code)	
Rollimore	, , ,			20a. Method of Disposition 1 Burial 2 Cremation 3		20h Place	of Dispositi		1	Date	20c. Location	on - City or	Town, State	
Hi.	permit. Page Department	any injury o		4 ☐ Donation 5 ☐ Other (Sp. 21. Sign 1 r of Fine 1 e vice Vice		Metro		ory ame and Addres		lie Funer	Baltimo		Dol+im	or Co
1 2	permit. Departr	any		My Co					Rd., Ranc				DETLUM	ore co.
X	- Ph∫si	cian/		23a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition	omplications that cause ly one cause on each lin	d the death. Do	o not enter ti	ne mode of dying	g, such as cardiad	or respiratory a	rrest,		Approxim Interval B Onset and	Between
18/6		dical niner		resulting in death)	a. Due to (or	a consequence	e of):	eL/	Jenno	Lare			8 mo	hths
<i>x</i> ■	ted	ınsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	e of): 1	Fh!	sercti	87				
10x 40	certificate be execut	: iš		that initiated events resulting in death) Last		a copsequence	1	Reh	aLE	e.lur	e			
Box		d be detached for use as the bu	Completed by Physician/Medical	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal dea	ath 3 🗆 E	ctopic pregnanc	у		- 1	Date of del Month	ivery Day	Year
P.O	The law requires that the death after the hearth after the hearth after the	ld be deta	d by PI	Part II. Other significant conditions		out not resulting	g in the unde	erlying cause giv	en in Part I.		tobacco use co			
Corc	law requi	s 2 should	nplete	Decubitus Ulcer	Buttocks					24a. Was			opsy finding	
Be	n: The I	or, page		Stasis Ulcer's	Lower Extr	emitys				1 Perf	ormed 202 No	death?	2 No	
Vita	ysicia is cert	direct	To Be	examiner?	Hospital: Inpati	ent 2 ER/0	Outpatient :	Othe	ace of Death (Che	lome 5 Resi	idence 6 🗆 C	other (Speci	fv)	
n of	Attending Physician: or death.	funeral		27. Manner of Death Natural 5 ☐ Pending Accident Investigat	28a. Date of inju (Month, Day	ry 28b	. Time of injury	28c. Injury work	r at ?	28d. Describe				
Division of Vital Becords	l or Attendi after death. Director: A	d in by the	Certificate:	A□ Accident Investigat 3 □ Suicide 6 □ Could no 4 □ Homicide determine	t be				Yes 2 No	28f. Location (City or To	Street and Nur wn, State)	nber or Rur	al Route Nur	nber,
(6)	To the Hospital or within 24 hours afte To the Funeral Dire	completely filled in by the funeral director, page 2	Medical	(Check 2 Medical Exa	hysician: To the best of aminer: On the basis of e	xamination and	/or investigat	ion, in my apinia	n death occurred	at the time date.	and place and	due to the o	ause(s) and n	nanner stated.
(4)	Nithi Total	com		29b. Signature and title or certifier	Sel O	1-		29c License	number		29d. Date sign			7_
				30. Name and address of person wh	o completed cause of d	eath (Item 23a)	(Type, Print	Nort	PSO Knesa	L Ha	in tal	- (este	12
2	Re	State gistra		81. Date filed (Month, Day, Year) MAY 29	2012 32. Begistra	ar's Signature	par			1,100	1-1		1.1.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month O55 Day 10:00AM Physician/ AVEN E MARIA Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** NURSING View Home Social Security Number If Unde If Unde 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. Hours 1 🗆 M 2 🗶 F 93 Director 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location aţ 10b. County Director traumatic event, the Medical Examiner must be notified 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number ö 23a Funeral "natural", or items Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event". Elementary/Secondary (0-12) College (1-4 or 5+) Tana Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ FRANCIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place tome 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (androwyst Physician or home disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year page 2 should be detached for Day 5 Other (specify) Pregnant at time of death the a 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) director, 25. Was case referred to medical Be examiner? Other: 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes မ within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral directors. 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certificate: 1 Natural 5 Pending Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

W/ State

Registrar

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MD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAUKA WASEEM - 709. BAST

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

709. BASTERN

29c. License number

BLUD,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2230 arle Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospital Center Westminster Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, Year) Months Hours Days 218-38-3283 Director 1 🛣 M 2 🗆 F Yrs. 70 Aug 9, 1941 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location must be notified at Director 1 Yes 2 X No Baltimore Reisterstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? o Funeral items 23a U.S.A. 300 Cantata Court 21136 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. ō þ 1 Never Married 2 Married 2 3 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Giant Foods Stock other traumatic event, Be permit. Page 1 and 2 should be filed. Department of Health and Mental Humortant: If item 27 is more any injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Frank J. DiPietro Charlotte W. Bostian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. DiPietro Sister 349 Walgrove Road Reisterstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/24/2012 4 ☐ Donation 5 ☐ Other (Specify) Zion Haugh Cem Keymar, MD 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final heymonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to or as a conse uence of) It any hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day ☐ Pregnant at time of death ☐ Unknown Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Keopirator an 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural work 1 🗌 Yes 2 🗌 No Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30/Name and address of person who completed cause of death (Item 23a) (Type, Print) Hosai 447. Main MO East State Registrar

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 8:21 AM Ethel Evans May 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 5 4 1 Baltimore 6000 Central Avenue Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🖼 F Director 220-22-2622 84 29, 1927 Maryland June Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, Item Mcdical Examinations and Illing at 1 ☐ Yes 2X No Director Baltimore MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 USA Funeral 6000 Central Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No þ Specify. Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Department Store Sales 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other trainment. 17. Father's Name (First, Middle, Last) Be Cora K. Eckels Frank A. Lane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1901 Catenacci Court; Petaluma, CA 94954 Jan E. Evans Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn, MD 5/29/2012 Lorraine Park Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee MO123 Y 23a. Part 1. Enter the digease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MYOCARDIAL Immediate Cause (Final **Physician** HO URS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a y last in the conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of: the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the as IE FEMALE use yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō 5 Other (specify) P.O. the detached 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler 29c. License number

State 31. Date filed (Month, Day, Year)
Registrar MAY 2.9

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #200&25 Per PHY G927 5/29/2012 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 9:30 PM Physician/ FRANCIS STEWART ELLIOTT 20,2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HARFORD BRIGHTVIEW ASSISTED LIVING AIR Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 If Under 24 Hrs Age (In yrs. last birthday, **Funeral** Days Months Hours Min 287-12-6883 1 X M 2 □ F Director LIMA, OHIO 10-9-1923 88 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 XNo HARFORD BEL AIR MD. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 300 W. RING FACTORY ROAD 21014 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Ty Yes 2 No
If Yes, Give 11-42-1946

Year or Dates. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinone. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: WHITE 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) JAG ATTORNEY ARMY Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ UNKNOWN UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1506 KITTERING COURT BEL AIR, MD. 21014 POA/FRIEND SUSAN ANN APPEL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 8/14/2012 FORT MYER, VA. 4 Donation 5 Other (Specify) ARLINGTON NATIONAL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BEL AIR BEL AIR, MD. 21014 610 W. MACPHAIL ROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ end 5 disease or condition 72 Due to (or as a consequence of) Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day for Month Pregnant at time of death Yes 2 No the g 9 Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 17 BP 24a Was an autopsy performed prior to completion of cause of death? ate has page 2 s 2 No 1 🗌 Yes this certificate Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 XX ASSISTED LIVING Other: 4 \sum Nursing Home 5 \subseteq Residence ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: After Natural 5 Pending Accident
Suicide Investigation within 24 hours after death

To the Funeral Director, A

completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗆 only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 32225 may 2012 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brock 19 º 615 CW, MARPHA NIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 05 Blanche Caroline 2012 Esche 01:50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Care Center Baltimore Towson Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) Months Min Hours (Month, Day, Year) Director 034-14-5019 88 1 🗆 M 2 🗓 F 05/10/1924 MA Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-f sho eny injury or other traumetic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits 1 🗆 Yes 2 💟 No Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 308 E. Seminary Avenue 21093 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🛣 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White If Yes, Give 3 X Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 end 2 should be filed within 72 nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dominic Vedovelli Caroline Calvi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Ann Esche, Daughter 147 D Versailles Cir. Towson, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial 05/24/2012 Fallston, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck. 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) phone Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ettending physician and for use es the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ဍ 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation

Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funerel Director: After this certificate has been six completely filled in by the funeral director, page 2 should I

Accident
Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 20^{ay} 2012 6:32 A M Bruce Bennett Flautt Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth g. Birthplace (State or Foreign (Month, Day, Year) Hours Country) Director 217-30-7448 1 X M 2 □ F 78 10/26/1933 MD Usual Residence of Decedent , or items 23a or 28a-f shov miner must be notified at 10a, State 10b. County Director 10c. City, Town or Location with the Maryland 10d. Inside City Limits 1 🗌 Yes 2 🕱 No Union Lewisburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 116 North Third Street U.S.A. 17837 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ò Black, White, etc. 1 Never Married 2 Married X Yes 2 No be filed within 72 hours after 21215-0036 1 ☐ Yes 2 X No Specify: "natural", If Yes Give Completed 3 Widowed 4 X Divorced Specify: Year or Dates. 1953-55 White other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Clerk MD Port Administration Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Flautt Thelma Osterman Porter permit. Page 1 and 2 should Department of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 27 Laura Liberman, Daughter 1 Cormer Ct. 103 Timonium, MD 21093 Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 A Burial 2 Cremation 3 Removal from State Most Holy Redeemer 4 Donation 5 Other (Specify) 05/22/2012 Baltimore, MD Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any leading to inmediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year the signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è been sig should k Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has e 2 autopsy performed Yes 2 s certificate has director, page 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 X No Other: ပ္ 1 Natient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of 29d. Date signed (Month, Day, Year) D0023166

State Registrar 6535 N. charles 5.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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orraine Fertsch		1- For State Registrar	tate of Marylan		tment of ficate of		and Menta		Reg. No.	201	
Physicia Ledical Exami		1. Decedent's Name (First, Midd Lorraine Ferts						2. Date of D Month April 16	Day	Year	3. Time of Death 0956 hrs
		4a. Facility Name (if not institution 1600 W. 41st Street	on, give street and numb	oer)	,	4b. City, Town Baltimor	n, or Location of I	Death	40	. County of Deat	N/A
Funeral Director		5. Social Security Number 090-54-8178	6. Sex 7.	Age (In yrs. last	t birthday) Yrs		Year If Under 2 Days Hours	Min, Nov.	Birth (MM.	/DD/YYYY) 9. Bi Forei	rthplace (State or gn BrookLyn, puntryNew York
,		Usual Residence of Decedent 10a. State 10b. County			own or Locat				10d. Inside City Limits		
nd show any ice.	×	Maryland	N/A		ltimor						1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	made 3-b	404		10f. Zip Co				zen of What Cou	
with the ns 23a o		2901 Boston St. 11. Marital Status	12. Was Deced	ent Ever in U.S.				? (Specify Yes or			rican Indian, Black,
ter death	Funeral		flarried Armed Force 1 Yes vorced If Yes, Give Yeer	es? 2 🔀 No	1	es, specify Ci		uerto Rican, etc.)		White, etc. Specify:	White
hours aft natural	ed by	15. Decedent's Education (Spe	or Dates: ecify only highest grade			it's Usual Occ	upation (Give king)		16b. I	Kind of Business	/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importact: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other tranmatic evect, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 14 Physician Family									y Practice
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic evect, the Medical	Be Co	17. Father's Name (First, Middle Charles Herber						Name (First, Middl ne Paulir			
mand 2121 (stands and 2 should be fill tealth and Mental F tem 27 is marked traumatic evect, it	Ę.	19a. Informant's Name/Relations					Street and Number				e, Zip Code)
Baltimore, MD permit. Pages I and 2 she Department of Health and Important: If item 27 is injury or other fraumati		20a. Method of Disposition		20b. Pla	ce of Dispos	ition (Name o	f cemetery,	Date			Town, State rd County)
Baltimore, permit. Pages 1 ar Department of Hee important: If ite		4 Donation 5 Other S	n 3 Removal from	Cre	mettion:	al Chape Service	s Inc.	Salturday, Mary 26,201	2 F	orest H	ill, Maryland
Balf permit Depart Impor injury		21. Signature of Funeral Service	we.	LIC. MUU)// i	2325 YO	DK HOEOL	THE THURSDE	aryla	10 Z109.	1 Center, P.A. 3-2215
Physician	V 11	2ka. Var. I. Enter the disease, or failure. List only one cause			o not enter th	ne mode of dy	ing, such as card	liac or respiratory	arrest, sho	ock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Salicylate Into								- Boust
ij.	ĕ	Sequentially list conditions, if any, leading to immediate	b Due to (or as a co	onsequence of):							
, i	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	ensequence of):							
executed an and al - transit	ल	UNPENDED	d	<u> </u>							
68760, certificate be nding physici se as the buri	/Med	IF FEMALE: 23b. Was decedent pregnant in t		come of pregnar		tal death	3 Ectopic pi	reanancy	23	d. Date of deliver	y Day Year
or u atte	Physician/Medic	past 12 months? 1 Yes 2 No 9 Un		t at time of death	~	her (Specify)				West (C)	Day Tour
O. B.	by Phy	Part II. Other significant condi			ulting in the u	inderlying cau	ise given in Part I		_		the cause of death?
ords, P.C. w requires that s been signed I should be deta		Peripheral Neuroecto	odermal Tumor					1\ 24a. W		24b. Were a	bably 4 Unknown utopsy findings available
of Vital Records, P.O og Physician: The law requires that the this certificate has been signed by meral director, page 2 should be detailed.	Completed							pe	topsy rformed? s 2 ✔ N	death?	completion of cause of es 2 No
ician: The certificate rector, page	Be.	25. Was case referred to medica examiner?	Mospital:		2/0. 11:1	-	lace of Death (CI	neck only one)	7000		
of Vi iog Physi After this	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of (Month: Date of FOUND)	Injury 28	R/Outpatient 8b. Time of Ir	njury 28c.	Injury at Work?	28d. Describ	e how inju	ury occurred	ir; Scene
Division tal or Atteodiars after death.	catio	2 Accident Inve	stigation Apr 16, 20		OUND: 950 hrs		Yes 2 V N	0 1			urat Route Number, City
Divi	Certification:	4 Homicide dete	ld not be	Other (woode		., 120101.9; 0111		or Town	, State)	eet, Baltimore,	•
pe E nin E	Medical	(Orlock only	hysician: To the best of	examination and/							
To with	Me	29b. Signature and till of certifu	and manner state	MA	0,50		cense number	_		Date signed (Mo	onth, Day, Year)
14		30. Name and address of person	who completed cause of	of death (Item 23	-/ Ba)		.C.M.E.	-	Apr	il 17, 2012 ————	
10 4		Victor Weedn MD JD	Assistant Medic	cal Examine	r 900 W	. Baltimor	e Street, Balt	imore, MD 21	223		
St Regist		31. Date filed (Month, Day, Year) MAY 2 9 2012	32. Regis	ar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Month 6:05AM Year **Physician** torman 2012 MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOS81 1 A1 BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Yrs. Birthplace (State or Foreign Country) 6. Sex Social Security Number 1 M 2 F **Funeral** Months Days Hours -22-2009 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Welfcal Evan, that the hydifical at once. 1 ☐ Yes 2 ☐ No ndalk Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 ISA News Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ary Gecondary (0-12) College (1-4or 5+) aborer 18. Mather's Name (First, 17. Father's Name (First, Middle, Last, Be 194. Informant's Name/Belationship (Treerened Daughter) 19b. Mailing Address (Street and Number Baltimore MD 21229 156 Stone Crot 20b Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State June 1, 2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line. Immediate Cause (Final O DAYS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year 5 ☐ Other (specify) the Ö detached 9 ☐ Unknown cate has been signed by a page 2 should be detach ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 ☐ Yes of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? completely filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Division 1⊠Natural 2 ☐ Accident 5 Pending 1 ☐Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortifier eted cause of death (Item 23a) (Type, Print) 3350 WILKERS AVE DUAINDO MID

Registrar
DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death . Decedent's Name (Fi st Middle, Last) Elizabeth Glerum 2. Date of Death Physician/ Month 5/19 5:45pm Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore **Examiner** 4b. City, Town, or Location of Death Charlestown Retirement Community Catonsville Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 079-01-5882 92 Days Hours Min. 12/13/1919 1 □ M 💥 F Director NY or 28a-f show with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director MD Howard Catonsville 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 709 Maiden Choice Lane, RGS 208 21228 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonce. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 XXIO Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give White Specify 3€ Widowed 4 □ Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Christopher Cook Armeda Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jonathan Glerum 1 Edge Springs Court, Catonsville MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 X Removal from State Newark Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 5/25/12 Newark, 21. Signature of Fune al Service LicenseeVictor P. Doda 22, Name and Address of Facility Charles L. Stevens Funeral Home, 1 1501 E. Fort Avenue, Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events burial-tran resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) ed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2.2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1- Natural injury 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours a Medical To the Hosp within 24 hou To the Funer completely fi 29a. Certifier Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4

32. Registrar's Signature

DHMH 17 Rev 06-2011

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2017 727 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A onns Himore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Age (In vrs. last birthday Days Min Hours Director 213-28-3374 1 XM 2 □ F Oct. 18,1931 Maryland 80 Page 1 end 2 should be filed within 72 hours efter death with the Maryland ment of Health end Mental Hygiene.

ent: If Item 27 is marked other then "neturel", or Items 23e or 28a-f show ury or other treumatic event, the Medical Everther must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 XNo Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 500 Westfield Road 21222 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by ∑XYes 2 ☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 St No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates. Korean White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Industry Steelworker 10 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Helen C. Reynolds Henry C. Grossman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
500 Westfield Road Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type, Print) Mrs. Gloria A. Grossman (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gdns. of Faith Cem. Department of H Importent: if ite any injury or ot Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/25/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat of Funeral Service Licenses Buda-Ruck Puneral Home of Dundalk, Inc. Dundalk, Maryland 21222 7922 Wise Ave. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam signed by the attending physician and d be detached for use as the burial-transi Cause (Disease or injury The law requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Pregnant at time of death 9 Unknown P.O. Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig ; page 2 should b Records, 1 Yes 2 No 3 Probably 4 Nunknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physic within 24 hours after death.

To the Funerel Director: After this or completely filled in by the funeral dire ဂ္ 1 Yes 2 1 No 1 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 [Certifying Nurse Practitioner: To the be my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year) Cex! 800 orleans 21287 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ 2012 20 7:14 p M Gaeger May Marsha Lynn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Dove House Westminster 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Davs Hours Min (Month, Day, Year) Country **Director** 232-62-4713 1 □ M 2🏗 F 71 Jan 2, 1941 WV Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 1 Yes 2x No MD Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ò must be r Funeral U.S.A. 761 Carbide Drive 21158 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. ö 1 Never Married 2 Married þ Maryland 21215-0036 White han "natural", Medical Exar If Yes, Give Year or Dates 1 ☐ Yes 2 🕱 No Specify: Specify. 3 X Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) المالية. خوا Hygiene. خمر than "r (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Customer Service Bowl America Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file h and Mental H 7 is marked o ပ Ramsey traumatic Henry Bennett Dorothy E. Crank Department of Health an Important; If item 27 is nay injury or other traum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 761 Carbide Drive Westminster, MD 21158 Kim Ann Abel Daughter 3altimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 5/24/2012 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 21. Signature of Fugeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, Maryland 21136 ELINE FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events and the burial-trai Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be P.O. Box 68760 use as ding IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day 5 Other (specify) Pregnant at time of death the a 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page 2 death? 2 7 Yes 2 I or Attending Physician: after death.
Director: After this certifications 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital INPATIEL 힏 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending by the f Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) filled in within 24 hours a To the Funeral L Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 06-2011

title of certifie

Day, Year

MAY 29

29b. Signature

29c. License number

(Type, Print) SA Westminst

S

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ack 2012 Germrot /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) 4,1939 **Funeral** Months Days 72 Maryland 212-34-9217 August Director Usual Residence of Decedent thould be filed within 72 hours after death with the Maryland of Mental Hygiene.

marked other than "natural", or items 23a or 28a-f show 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County ms 23a or 28a-f show must be notified at ty∑ Yes 2 ☐ No Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 4822 Aberdeen Avenue 21206 U.S.A. Funeral ıral", or items 2 I Examiner mus Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify. Specify ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) General Manger-Vice President Food Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be a nent of Health and Mental I Howard Germroth Anna J. Holden 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (S) Kay A. Germroth: Wife item 27 4822 Aberdeen Avenue, Baltimore, Maryland 21206 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or o oonce. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-23-12 Cremation, Inc. Hanover, Maryland Ardent 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael P. prayulli-6009 Harford Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death))/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) attending physician Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the at 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ should be 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy after death.

Director: After this certificate has performed 1 🗌 Yes 2. No 1 🗌 Yes 2 No Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1X Inpatient Other: 4 Nursing Home 1 🗌 Yes 2 🗹 No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation Injury 2 🗌 No 1 Yes 2 Accident completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30 Name and address of per 1aria Berenice 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) State 2 9 2012 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G928 6/28/2012 JH State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) $\stackrel{ ext{Month}}{ ext{MAY}}$ Physician/ 2012 05:15P M GORN MARGARET Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE STEVENSON 10530 STEVENSON ROAD 9. Birthplace (State or Foreign Country), MD If Under 1 Year If Under 24 Hrs. Date of Birth 7. Age (In yrs. last birthday) Spq aLSequoy LLY 945 **Funeral** Hours Min. 1 🗆 M 2 🛛 F Months Days 0570471920 92 Yrs. 214-20-4428 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County at the Maryland Director notified 1 Yes 2 No STEVENSON MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 23a or pe Funeral with 1 Examiner must 10530 STEVENSON ROAD 'natural", or items hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11 Marital Status es, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) within 72 life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ THORNTON ALEXANDER UNKNOWN UNKNOWN and 2 should by Health and Mei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 14 CROSS CREEK COURT, PHOENIX, MD 21131 SUSAN GRANT / FRIEND or other 20a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) BETH EL MEMORIAL PARK 05/25/2012 4 ☐ Donation 5 ☐ Other (Specify) RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License MD 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final at sovegrony Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner COD 9 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami PINDMUTERA Cause (Disease or liniury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be Box 68760 the as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day or Attending Physician: The law requires that the death ò 5 Other (specify) Pregnant at time of death 9 Unknown the 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ be 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy has performed certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral (28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Director: After work? injury Natural 5 Pending 2 🗌 No Accident Investigation filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Pwithin 24 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) -2048 201 ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 700 CACSEN 31. Date filed State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 16672 Certificate of Death 's Name (First) Middle, Last 2. Date of Death 22 Day 2012 Physician/ May \mathcal{A} 7:08 p^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Greater Baltimore Medical Center Baltimore Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours Min. 1 ▼M 2 □ F **Director** 87 2-5-192 28a-f show 10c. City Town or Location Department of Health and Mental Hygiene. Important: in items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once. 10d. Inside City Limits Completed by Funeral Director ikesville 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 21208 evenson 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during lifet DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Be 2 cose Type, P(Daughter) Heren son 20b. Place of Disposition (Name of or other place) 1 Burial 2 Cremation 3 Removal from State Y cemetery, crematory rownsville ownsville. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 5151 Balto. National Pike 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Cardiomyonaflu Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-trans Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be defached for use as the burn completely filled in by the funeral director, page 2 should be defached for use as the burn. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month 5 Other (specify) Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 \(\triangle \text{ Nursing Home } 5 \) Residence 6 \(\triangle \text{ Other (Specify)} \) Hospital 2 1 Dempatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) · Cyntina Juden 00057347 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) charles St Buttinose MS 2/204 6761 N

State Registrar

DHMH 17 Rev 06-2011

SNIAN

State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2012 Physician/ May 26, 11:15 A^M Hensgen Hussong Marie Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days Hours Months **Director** 158-30-8070 1 M 2 XF 94 February 27, 1918 New Jersey Usual Residence of Decedent 28a-f shov 10d, Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Funeral Director 1 X Yes 2 No Rockville Montgomery Maryland 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20850 9519 Veirs Drive #2 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 😿 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Church Organist/Choir Director Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Bertha Eppinger Eugene H. C. Hensgen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 777 Paul Birch Drive, Crownsville, Maryland 21032 Katherine Harmon/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 XCremation 3 Removal from State May 28, 2012 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 22. Name and Address of Facility Funeral Home/Bethesda-Chevy Chase, Inc. Signature of Funeral Service Licenses meny fin 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration
ue to (las a consequence of): pneumonia disease or condition Medical resulting in death) **Examiner** ronic Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy funeral director, page 2 performed 1 ☐ Yes 2 ☐ No Yes 2 N 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certificate: To Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending n 24 hours after death, e Funeral Director; After eletely filled in by the fur Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier To the Hosp within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0067386 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, MD 20150 OV medical Ctr Dr SoniamJohn 9901

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 31. Date filed (Month, Day,

			Please Typ							-		egible.		
			Sta L_State	ate of Ma	aryland		rtment of H		and M	lental Hy	giene	001	0	6671
	_		Registrar 1. Decedent's Name (First, Middle, Last)			Cer	tificate of L	Jeatn		2. Date of De	Reg. No.	201	7	PP 17
П	Physicia		Elizabeth Patricia	Haac						Month MAY	Day	2 0 13	3. Tir	D A M
-	Medic Examir		4a. Facility Name (if not institution, give street a				4b. City, Town, o	r Location (of Death	11111	4c. Co	ounty of Dea	th	
1			MEDSTAR FRANKLIN SQUARE HOSATAL ROSEDALE							Bal			nore	
9	Funeral Director		5. Social Security Number 212–36–9019 Usual Residence of Decedent		e (In yrs. las 73	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 12/05/	B. Date of Birth 9. Bi (Month, Day, Year) Co 2/05/1938 Ma:			ate or Foreign d
	and show lat	o.	10a. State 10b. County		10c. City,	, Town or Loc	ation						10d. Insi	de City Limits
	Maryl 28a-f otifiec	Director	Maryland Baltimore			Middl	e River						1 🗆	Yes 2 X No
	h the		10e. Street and Number				10f. Zip Code				10g. Citize	n of What C	ountry?	
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Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland f Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 If	ned Forces? Yes XX 'es, Give ar or Dates.		If	/as Decedent of H Yes, specify Cuba ☐ Yes ※ No	ın, Mexicar	n, Puerto I	Rican, etc.)		. Race - Ame Black, Whit ecify:		n,
5-0	hour "natu dical	Completed	15. Decedent's Education (Specify only highest grade com			16a. Deced	ent's Usual Occup	ation	t of worki	aa	16b. Kind	of Business	/Industry	
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d 2	ed wit Hygie other ent, th	Be C	10 17. Father's Name (First, Middle, Last)			Abben	mier	18 Moth	or's Name	e (First, Middle,			rer	
an	l be filed lental Hy, rked oth tic event	မ	Antione Novotny							Hajal		riarroj		
ary	should be and Me		19a. Informant's Name/Relationship (Type, Prin	nt)		19b. Mailin	g Address (Street	and Numbe	er or Rura	I Route Numbe	er, City or To	wn, State, Z	ip Code)	
Σ	1 and 2 s of Health item 27 i		Robert Allen Haas (Se	on)		2703	Bay Driv	e, Sp	arro	ws Poi	nt , M	id. 21	219	
ore	ge 1 au t of H If ite or oth		20a. Method of Disposition 1 ☐ Burial 2 🄀 Cremation 3 ☐ Remove	al from State	ce	metery, crem	sition (Name of atory or other plac			Date	l	ition - City o		
tim	t. Pag rtmen rtant: rjury		4 ☐ Donation 5 ☐ Other (Specify)		Bay		rematory							
Ba	permit. Page 1.8 Department of F Important; If its any injury or of		21. Signature of Fune a Service Licensee	<u> </u>			Name and Addre Br 407 old					e, P.A , Mar	iand	21221
e se	Physician/		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus Immediate Cause (Final disease or condition	e on each line			r the mode of dyin	_			rrest,			kimate I Between and Death
-	Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):								
		je.	Sequentially list conditions, b. ——if any, leading to immediate	Due to (or as a	conseque	ence of:								
	nted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury			,								
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Division of Vital Records, P.O.	: The law recate has be ; page 2 sh	Completed by								24a. Was auto perfo 1 \square Yes		prior to death?		ngs available n of cause of
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uc	ath. r: Afte	icat	1 Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	(Month, Day	, Year)	injury	M 1 🗆	? Yes 2 🗌	- 1					
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	he Hospi iin 24 hou he Funeri ipletely fill	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: 7 Certifying Physician: 7 Certifying Nurse Pract	the basis of ex	amination	and/or investi	gation, in my opinic	on, death oc	ccurred at	the time, date:	and place, ar	nd due to the	cause(s) an	d manner stated.
	To To COU		29b. Signature and title of certifier Defin Awil				D 00	617			MAY	igned (Mont	20	12.
200	_		30. Name and address of person who complete LIPPANE OF AWU	HIMO.	eath (Item 2 5430	23a) (Type, Pi <i>CABY B</i>	int) ELL BLVO	STE	214	BALT	MOR	E, MO	212	36.
	Stat Registra	.6	31. Date filed (Month, Day, Year) NAY 2 9 2012	32. Registra	r's Signatu	bark								
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dams Michael	Her	nrich State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2012	166
Physici Medical Exam		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Very	Time of Death 0600 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 8003 DuVall Avenue 4c. County of Death Rosedale Baltimore County	,
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthpla	ace (State or
Director		2/4-25-9243 1 VM 2 F 27 Yrs. Months Days Hours Min. 8/4/1984 Foreign Country Usual Residence of Decedent	1) MD
w any		10a. State 10b. County 10c. City, Town or Location 10d	d. Inside City Limits
Maryland 28a-f show d at once,	ctor	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	Yes 2 No
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f showmatic event, the Medical Examiner must be notified at once.	Director	8003 Duva1/ Avenue 21237 USA	
eath with items 2:	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American I White, etc.	Indian, Black,
after de	by Fu	3 Widowed 4 Divorced of Paragraph Divorced of Paragraph Divorced of Divorced o	2
72 hours afte matural",	eted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FENCING	atry
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Completed	17. Father's Name (First, Middle, Last) Laborer Laborer 18. Mother's Name (First, Middle, Maiden Surname)	ON
21215-0036 uld be filed within 72 hours after d Mental Hygiene. marked other than "natural", or c event, the Medical Examiner m	Be C	Michael W. HeINRICH Kathleen ANN Krembel	/
MD 21 d 2 should th and Me n 27 is ma	J.	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, Itate, Zip 19c. Mailing Address (Street and Numbe	Code)
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Balti permit. Departu Importu injury o		Dially - British an	(1222)
Physician /Medical		failure. List only one cause on each line.	pproximate Interval setween Onset and Death
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	ler	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
ا ي	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
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Box 68760, e death certificate be the attending physic of for use as the bur	ician/N	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	Year
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On O ending J ath. or: Afte		27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 1 Natural 2 X Accident 1 Netural 28a. Date of Injury (Month, Day, Year) 1 Yes 2 X No 28d. Describe how injury occurred subject ingested met	hadone
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Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		4 Homicide (Specify) Found: Residence Rosedale, MD. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
To the Hos within 24 h To the Fu	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cau and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, D	
		O.C.M.E. May 26, 2012	ray, roary
	Ì	30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
	ate	31. Date filed (Month, Day, Year) 32. Resistrats Signature	
Regist	_	ORIGINAL OCAME	
OCME 2006		ONGHAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Helferstay Kimbal 8:59PM Hunter . Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard Columbia Gilchrist Hospice If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 93 Director 212-14-6822 09/08/1918 MD Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Director 1 Yes 2 X No Catonsville MD Baltimore 10f. Zip Code 10e, Street and Numbe 10g, Citizen of What Country? Funeral 21228 USA 715 Maiden Choice Lane, HV208 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner rmed Forces?

Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 0 ģ 1 Never Married 2 Married within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", White Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) **5+** the Law Firm Attorney Be traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Catherine Boward Roy C. Helferstay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 Maiden Choice Lane, HV208, Catonsville, MD 21228 of Health Meream B. Helferstay 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Department of Important; If it any Injury or o once. 1 Burial 2 Cremation 3 Removal from State 05/26/2012 Hagerstown, MD Rosehill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sergice Licensee Hubbard Funeral Home, Inc. Ave., Baltimore, MD 21229 4107 Wilkens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septicemia Pnysician/ Week disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ysphagia Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Accident erebro vascular and tran that initiated events Due to (or as a consequence of) resulting in death) Last burial physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Day Month Pregnant at time of death 2 No the a be detached 1 ☐ Yes 2 L g ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2- No 24a. Was an autopsy performed? certificate has Yes 2 completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 I ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at work? Certificate: 1 Natural 5 Pending s after death. 1 Tes 2 No Accident Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) DOGG 0632 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ :01 a Thomas W. Hynes Medical 4a_Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Town, or Location of Death Sauare 0 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 144-46-5653 Min. Director 1 ₹ M 2 □ F 61 06/26/1950 New Jersev Usual Residence of Dece ms 23a or 28a-f shov must be notified at 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Maryland Baltimore Parkville 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 9211 Avondale Road 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or amy injury or other traumatic event, the Medical Examinane. 11717000 (1107170と) Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Automobile Dealership Auto Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Franklin Hynes Viole Hahn . 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Hynes 9211 Avondale Road Parkville, Maryland 21234 Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place)
LastRidgeLawnCrematory 5-25-12 Clifton, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel 6009 Harford Road Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine cause. Enter Underlying
Cause (Disease or injury Due to for as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ g ☐ Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been signector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1 Yes 2 No Hospital Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number SG1200 H- WOLDETHINDT D0063327 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1000 Franklin Square

Registrar

Bany Miggins 12-03895 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

INK UNK		State of Maryland / Department of Health and Mental 1- For State Certificate of Death Registrar		Reg. No. 201	2 1667
Physiciar Medical Examin	n/	1. Decedent's Name (First, Middle,Last)	2. Date of De Month May 22, 2	Day Year	3. Time of Death 0545 hrs
jedicai Examini		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De		4c. County of Death	<u> </u>
Funeral	٩	3207 E. Fairmount Avenue Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	4Hrs. 8. Date of B	irth(MM/DD/YYYY) 9. Bir	
Director	4	213-94-7519 1×M 2 F 33 Yrs. Months Days Hours	Min. 10-0	6-1978 Foreign	on Mary land
any	F	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
B .1	5	Maryland Harford Joppa			1 Yes 2 No
te Maryland or 28a-f show fied at once.	irect	10e. Street and Number 10f. Zip Code 21085	I	United S	tates
eath with the Maryland items 23a or 28a-f abo	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or N		ican Indian, Black,
E 9 1		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: B	lack
5-0036 led within 72 hours after thygiene. The Medical Examiner.	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		16b. Kind of Business/	Industry
036 thin 72 ne.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		Factor	9
P 등 등 등 학	ဂ် ပ	1	ame (First, Middle,	Maiden Surname)	
2121 hould be fil nd Mental I is marked	8 L	19a. Informant's ame/Relations ip (Type, Print) 19b. Mailing Address (Street and Number	or Rural Route Nu		
MC 2 s alth au 27 rsum.	1	Jheila Buchanan - Aunt 500 Dambytou 20a. Method of Disposition (Name of cemetery,	W n Road Date	20c. Location - City or	
Baltimore, bernit. Pages I a Department of He Important: If ite		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Community Boot Chi Community	May 31, 201	2 Joppa.	mp
Baltimo permit. Pages Department o Important: injury or oth		21. Signature of Funeral Service Licensee 22. Lame and ddress of Facility	0,144 A1	nu FJ, F	PA. 21728
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardifailure. List only one cause on each line.	ac or respiratory a		Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	xication		Death
		Sequentially hat conditions,	_		
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): c.			
cuted nd transit		events resulting in death) Last Due to (or as a consequence of): d.	0 10		
O, e be executed rsician and burial - transit	edical	☐ AMENDED 23a,27,28a-f,per me,g928 6-1	9-12 sm	23d Date of deliver	
Box 6876(death certificate the attending phy defor use as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specific)	egnancy	250. 250.0	Day Year
Box e death c the atten ed for us	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown			
P. Sthat	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use contribute to es 2 No 3 Pro	
ords, w require us been si	Completed			opsy prior to	utopsy findings available completion of cause of
ial Reccian: The lavecertificate has	E O		1 ✓ Yes	formed? death? 2 No 1 Y	es 2 No
of Vital Records, ng Physician: The law requir ther this certificate has been is neral director, page 2 should be	8	25. Was case referred to medical examiner? 1 ✓ Yes 2 No		Residence 6 🗸 Othe	r: Scene
ding Phy	음	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 1 Yes 2 X No	1 .	e how injury occurred	
Division pital or Attendit ours after death. teral Director: A	Certification:	2 Accident Investigation Investigation Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location	(Street and Number or Restate 2207 F. F.	ural Route Number, City
Div ospital o hours afi ineral D	₽ 8	4 Homicide determined (Specify) Found: In Vacant House	Baltime	State 3207 E. Fa	
To the Hos within 24 h To the Fun	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	red at the time, dat	e and place, and due to the	ne cause(s)
E 3 E 3	Me	29b Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mo	onth, Day, Year)
	-	30. Name and address of person who completed cause of death (Item 23a)		,, 25	
		Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	re, MD 21223	-	
Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State State of Maryland / Department of Health and Mental Hygiene State Registrar 24a,26 per verb., 8927, 05/29/2012dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ mmea GLORIA 1:30 0 5 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Himore Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Month Min **Director** 1 □ M 2 🗶 F 3-16-1952 60 MD Usual Residence of Decedent 28a-f show 10c. City, Town or Location filed within 72 hours after death with the Maryland at 10a. State 10b. County 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 X Yes 2 □ No MD Hmore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SSionar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 2 Vames Jackson traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Ty or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Middle 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) rematory or other place) cemetery, Randallstown March FIH-East 1101 E. North Ave Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to Vr s **Examiner** SC lars if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine apel ers burial-transi and Due to (or as a consequence of) Physician/Medical lars or Attending Physician: The law requires that the death certificate be 68760 the for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death signed by the at Id be detached for g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2 No certificate 2 🗌 No 1 Yes the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \square Nursing Home 5 \blacksquare Residence 6 \square Other (Specify) 1 Yes 2 No မ 1 🗌 Inpatient 2 🗆 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 🗌 Yes 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No within 24 hours after death. To the Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the P Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

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CARLOS

31. Date filed (Month

M.D

. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Towson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margaret D. Jacobson 3:25 PM MAY Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore MD N/A If Under 1 Year If Under 24 Hrs. **Funeral** 216–14–0492 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Hours 90 3/.25/22 **Director** 1 □ M 2 🖎 🖈 or 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1614 E. Fort Avenue 21230 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 2X No 1 Yes 2 KNo Specify: White "natural", 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Factory 8 Worker Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Richard Seaburs Rose Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Jacobson /Son 1446 Reynolds Street, Baltimore MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date cemetery, crematory or other place)
Cedar Hill Cemetery Burial 2 Cremation 3 Removal from State 5/29/2012 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign Charles L. Stevens Funeral Home, Inc. Victor P. Doda 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Preumonia Physicia / WEEK Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Exami Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 No Accident Investigation 1 Yes Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) within 24 hours a

To the Funeral D

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/on investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

DHMH 17 Rev 06-2011

State

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION MEMORIAL HOSPITAL MICHAEL SHTEYMAN, M.D. 200E. UNIVERSITY PKWY. BALTIMORE, MD 21218

AT 2438946-DIS

Michael Shteyman, M.D.

31. Date filed (Month, Day, Year)

MAY 2 9 2017

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 668 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 28am Physician/ Month Holroyd Robert Johnson, Sr. Medical acility Name (if not institution, **Examiner** give street and number, or Location of Death 4c. County of Death 1924 Hospital N/A ma Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex If Under 1 Year **Funeral** Months Days Hours St.Am, Janaica July 29, 1933 103-68-8081 78 Director 1 M 2 □ F Usual Residence of Deceden or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. Count Director 1 Ves 2 No Maryland Baltimore County Catonsville ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral within 72 hours after death with 16 Fusting Ave. 21228 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, th and Mental Hygiene. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner. Black, White, etc. 1 Yes 2 No by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♣No Specify: Jamaican Specify 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 06 Head Master Private High School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Alexander Johnson Caroline Weir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr.Andrew Warren Johnson (Son) 9318 Strong Box Way San Antonio, Texas 78254 27 item 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl
once. (Harford County) 1 Burial 2 Cremation 3 Removal from State Saturday, June 02,2012 Evans Funeral Cravel and Forest Hill, Maryland 4 Donation 5 Other (Specify) Cremetion Services, Inc. Pencerul Alternatives Funeral and Cremation Center, P.A. Hof Funeral Service **Lic.#M00677** 2325 York Road Timenium, Maryland Approximate Interval Between Onset and Death polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sease, or co shock, or hear failure. List onl Immediate Cause (Final disease or condition Physician, Medical resulting in death) Examiner alae if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death g Unknown P.0/ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Johnson examiner? Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A completely filled in by the fi Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature d title of certifier shinse 30. Nante and address of person who completed cause of death (Item 23a) (Type, Print) nvoluta

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ ohnso 170 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County, of Death **Examiner** 'olumbia Howard Year If Under 24 Hrs, Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Country **Director** 28a-f show 10b. County 10d. Inside City Limits aţ 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director or than "natural", or items 23a or 28a-f street the Medical Examiner must be notified High 1 X Yes 2 No towar 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 2077 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Medic other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 7. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked or any finjury or other traumatic ever ၉ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20771 Ka mma Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) 4 Donation eral Service Licens Horse 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ years disease or condition Medical resulting in death) or as a consequent of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death been signed by the sahould be detached Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: iniury 5 \square Pending Natural Investigation Accident filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Shirley Physician/ D. Klimek 6:48 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES HOSPITAL BALTIMORE ST Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 90 Months Days 1 M 2 F Hours Min 058-18-6369 Yrs **Director** 12/23/1921 NY Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland at Director Catonsville Baltimore MD Examiner must be notified 1 X Yes 2 □ No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 Funeral items 23a 715 Maiden Choice Lane USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. 9 þ 1 Never Married 2 Married 1 ☐ Yes 2√1 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 🔀 ★o Specify: White "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) within 72 and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other ဂ္ Jennie Duvall Earl F. Decker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
30 Munroe Rd Lexington MA 02421 19a. Informant's Name/Relationship (Type, Print) Klimek Son Daniel Ε. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5/29/2012 Albany NY 4 ☐ Donation 5 ☐ Other (Specify) Gardens Cemetery Memory ²² Name and Address of Facility Charles L. Stevens Funeral Home, Inc. Victor P. Doda 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Metabolic Acidose disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Gastro-intestinal month Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Examine Due to for as a consequence of: burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Colon Cance urknown Due to (or as a consequence of) nding physician Physician/Medical law requires that the death certificate be Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Por Month Day Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy has Hospital or Attending Physician: The certificate Yes 2 N **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မူ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After iniury work? 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director. Af completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Dav. Year) M.D Megnalshi, P-26615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD

DHMH 17 Rev 7/2009

State Registrar AVENUE,

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	For State Registrar	State of Mar		partment of l Partificate of L			giene Reg. No. 201	2 1668								
ian/	Decedent's Name (First, Middle, L Penny	ast) Shaw	Ko1			2. Date of Deat May 22	th	3. Time of Death 1:30 P M								
iner I	4a. Facility Name (if not institution, gi 2427 Mill Ra 5. Social Security Number 6. 106–36–9962	Ce Road Sex 7. Age (II	n yrs. last birthday) 8 Yrs.		r Location of Death rederick If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April II	9. Bi	erick erick ountry) New York								
ector	Usual Residence of Decedent 10a. State 10b. County Maryland Fre	derick	0c. City, Town or L		rederick			10d. Inside City Limits 1 ፟፟፟ Yes 2 ☐ No								
Funeral Director	10e. Street and Number 2427 Mill Ra			10f. Zip Code	21701		10g. Citizen of What C	•								
\$	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	r in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:									
Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12)		i (Give	edent's Usual Occup e kind of work done o DO NOT use retired) Office M	during most of work	ing	16b. Kind of Business Medical	Research								
To Be	17. Father's Name (First, Middle, Las		g	011100 11	18. Mother's Nam	e (First, Middle, N	Maiden Surname)									
	19a. Informant's Name/Relationship Kenneth P. Kols 20a. Method of Disposition	on / Husband		7 Mill Ra	ce Road,	Frederic	City or Town, State, Zck, Marylan 20c. Location - City o	nd 21701								
	1 ☐ Burial 2 X Cremation 3 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Light	☐ Removal from State ecify)	cemetery, cre Montgomery	crematorium	,Inc. May	26, 2012	Bethesda, Bethesda-Chev	Maryland								
	23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused th	101360 7	557 Wiscons:	in Avenue,	Bethesda,	Maryland 208									
	Immediate Cause (Final disease or condition resulting in death)		1 Year													
cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):															
Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 【X No 9 ☐ Unknown	23d. Date of de Month	elivery Day Year													
by	Part II. Other significant conditions	bacco use contribute t	o the cause of death? Probably 4 Unknown													
Completed		sy prior to med? death?	utopsy findings available completion of cause of es 2 No													
To Be	25. Was case referred to medical examiner? 1 Yes 2 XNo 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of injury	2 ER/Outpatie	ent 3 DOA Othe	4 U Nursing Ho	me 5 🔀 Reside	ence 6 Other (Spe	cify)								
	1 X Natural 5 ☐ Pending	reet and Number or Ru														
	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	t be 28e Place of Injuny		reet, factory, office		City or Town	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
Medical Certificate:	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine 29a. Certifier 1 Certifying Pl (Check 2 Medical Exa	28e. Place of Injury building, etc. (5	Specify) r knowledge, death nination and/or inve	occured at the time	on, death occurred at	d due to the caus	se(s) and manner as st	tated.								
edical Certificate:	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine 29a. Certifier 1 Certifying Pl (Check 2 Medical Exa	28e. Place of Injury building, etc. (6 paysician: To the best of my miner: On the basis of examurse Practioner: To the best	Specify) knowledge, death nination and/or invest of my knowledge,	occured at the time stigation, in my opinic death occurred at the 29c. License	on, death occurred a e time, date and place	d due to the caus the time, date an se, and due to the	se(s) and manner as st	tated. cause(s) and manner stated s stated. th, Day, Year)								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per inf g928 6-1-12 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ May 23 9:47 P M 2012 Henry Kumm. Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4h City Town or Location of Death **Examiner** Montgomery Suburban Hospital Bethesda Date of Bir... (Month, Day, Year 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 □ F Months Days Hours Min New York **Director** 079-01-7341 92 January 1920 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 X No Potomac Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 United States 10724 Rock Run Drive , or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces?

1 XYes 2 If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed WWII 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cartographer Federal Government filed v Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be Katherine Seiler Henry Kumm, Sr. 19a. Informant's Name/Relationship (Type, Print)

Loraine Katherine Kumm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra 10724 Rock Run Drive, Potomac, Maryland 20854 Lorraine K. Kumm / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. May 27, 2012 Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. J. Hr 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Chronic Obstructive Lung Disease Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Por Year Pregnant at time of death detached Unknown 9 🗌 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed k should be det 23e. Did tobacco use contribute to the cause of death? by Cancer of Lung, Hypertension, Aspergillus Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed? Yes 2 X No death? 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: Other: 1 Tes 2 X No ျ 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.
Funeral Director: After this eleted filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XNatural injury work? 1 ☐ Yes 2 ☐ No 5 Pending M Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

30x,1

State Registrar 31. Date filed (Month, Day, Year)

AAY 2 9 2012

32 Per Strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Graf,

Martin W.

MIL

07162

May 24, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2012 Month Physician/ Isaac Isom Kitchen, Jr. 3:30 A M 22 May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Pasadena 218 Magnolia Avenue Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Days Min. 1 🔀 M 2 🗆 F Month, Day, 10/13 74 Kentucky **Director** 213-34-5866 11937 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Linthicum 1 Yes 2 No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21090 USA 1209 Gloria Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 √ Widowed 4 □ Divorced Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical ! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Shipping Retail Dock Supervisor 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Florine Abrams <u>Isaac I. Kitc</u>hen, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Donna Hiltner / Daug. <u>218 Magnolia Avenue, Pasadena, MD 21122</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Sykesville, MD 4 Donation 5 Other (Specify) 5/26/2012 Lakeview Mem. Pk. 21. Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the dillase, o complications shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the burial physician Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Cther (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 2 N Yes **Division of Vital** 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ► No 4 Nursing Home မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending work? 1 Natural 5 Pending 24 hours after death.

Funeral Director: Af 2 Accident
3 Suicide
4 Homicide Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

24 A Magothy Beach Rd Pasadena,

30. Name and address of verson who completed cause of death (Item 23a) (Type, Print)

Janser

Tracy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 Physician/ 5:15 AM James M. Kearns Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner pper Chesapeake Med C+ If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 218-68-9233 Days Director 11/14/1954 Connecticut "natural", or items 23a or 28a-f show dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Harford Maryland Street 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 21154 3537 Millers Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by 1 Yes 2 1 ☐ Yes 2 No Specify. Specify: White 3 ₩ Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Master Plumber Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Sheehan William Kearns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3537 Millers Road Street, Maryland 21154 Sean P. Kearns Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Inc. 05/24/2012 Hanover, Maryland 21. Signature of Funeral Service Licensee

Ducket | Margello 22. Name and Address of Facility Marzullo Funeral Chapel, P.A 6009 Harford Road Baltimore, maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) day Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mellitus 1 Yes 2 No 3 Probably 4 Wonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Vital 26. Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မှ 1 Donpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) of 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident **Division** Investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: A Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2062445 m on who completed cause of death (Item 23a) (Type, Print) 500 Uppe Chesa 31. Date filed (Month, Day, State MAY 2 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lasalle Physician/ Month Day Christine MAGI 5:054 M 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shangri La Assisted Living Ellicott City Howard If Under 1 Year | If Under 24 Hrs. | 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 103-07-0459 Hours 3/5/15 Country) 97 **Director** 1 □ M 2**X** F 28a-f show iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Ellicott City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3649 Ligon Rd 21042 USA death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: "natural", 3 ₩Widowed 4 □ Divorced White Completed Year or Dates 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Cashier/Bookkeeper Importing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dominic Bettino Antoinette Cicero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 st ment of Health a tant: If item 27 is Arthur Lasalle / Son 3649 Ligon Rd, Ellicott City MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Kemoval from State 5/23/12 St. Joseph Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Niagara Falls, NY neral Service Licensee Victor Doda 22 Name and Address of Facility Charles L. Stevens Funeral Home, 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ GI Bleed disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examir cause. Enter Underlying burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown asn 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? jo signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops within 24 hours after death.

To the Funeral Director; After this certificate I completely filled in by the funeral director, pag 2 No 1 ☐ Yes 2 ☐ No Yes the Hospital or Attending Physician: ' 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence 6 other (Specify) Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending iniury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSkykpalneMD 5/17/12 DOUS 7465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NS Ray RIDAKSE MD 2835 Baltimore 21709 Smith AV 2 603 Date filed (Month, Day, Year) State 292012 Registrar

HMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY 8:17A CHARLES 23 WILBUR **LYONS** 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month Day Year) Director 1 🕱 M 2 🗆 F 235-24-0641 89 21. 1922 Pennsvlvania show 10d, Inside City Limits at 10a. State 10b. County 10c. City, Town or Location Director or 28a-f sl 1 🗌 Yes 2 🔀 No Frederick Woodsboro Maryland 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? must be 23a Funeral 10850 Renner Rd. 21798 U.S.A. items ; death v 12. Was Decedent Ever in U.S.
Armed Forces? 1942-45
1 X Yes 2 1942-45
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. "natural", or 1 Never Married 2 Married Completed by 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: 3 Widowed 4 Divorced Year or Dates. 1951-52 White event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) cryptoanalyst Federal government and Mental Hygie is marked other Be Department of Health and Mental H Important if fiem 27 is marked off any injury or other traumatic and one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Olive Virginia Post Chauncey Gilbert Lyons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Lyons Jr./_son Sandstone Butte Rd. Powell, WY Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) 6/5/2012 Bennett Butte Cem. Clark, WY 22. Name and Address of Facility Hartzler Funeral Home, P.A. of Juneral Service Lice New Windsor, MD 21776 Box 249 the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final 4 theroselent cdivase var Ph, sician/ DiFlace disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of, Exami the Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Dav Year Pregnant at time of death 1 Yes 2 g Unknown ed by the a detached t Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has te 2 autopsv page perform Yes 2 No 2 🗌 No certificate 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' 2 No Hospital 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral I Medical 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WDD Name and address of person who completed cause of death (Item 23a) (Type, Print) Woodsboro MD 21798 Dermi State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Elmer Lambert, Sr. 26 Lee May 2012 6:15 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Citizens Care & Rehabilitation Ctr. 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Days Hours Director 217-28-6200 1 🕱 M 2 🗆 F 81 Jan. 17, 1931 Maryland Usual Residence of Dec or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Maryland Frederick Woodsboro o 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or must be r Funeral 10 Rosewood Ct., #312 21798 U.S.A. or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 nan "natural", Medical Exan 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) th and Mental Hygiene.
77 is marked other than traumatic event, the Me construction/ Elementary/Secondary (0-12) College (1-4 or 5+) carpenter/ custodian public school 7 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Page 1 and 2 should be Norman G. Lambert Lena N. Kolb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health item 27 Greta F. Lambert/ wife 10 Rosewood Ct., #312 Woodsboro, MD 21798 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date of 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 5/30/2012 | Rocky Ridge, MD Breth. Cem. Sign tive of Mneral Service Lice 22. Name and Address of Facility Hartzler Funeral Home, P.A. atta 404 Main St Woodsboro, MD 21798 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres Approximate shock, or heart failure. List only one cause Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy be detached for in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown No page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 L Yes Yes the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital No Other: Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury a Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. M Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) 24 hours Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause pation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Day, Year) 29d. Date signed (Month, RY

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who comple

Robert L.

31. Date filed (Month, Day, Year)

Kaufn

lann

300 W.

9th St

Frederick.

MD 21701

ed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fh g927 5-29-12 vt
State of Maryland 7 Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 15 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, If Under 24 Hrs. **Funeral** Min. Director MM 2□F 90 or items 23a or 28a-f shov State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Baltimore MD 1 Yes 2 No 10g. Citizen of What Country? 21223 Funeral 1 and 2 should be filed within 72 hours after death with of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 29.9 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 Yes 2 ☐
If Yes, Give Black, White, etc Completed by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) econdary (0-12) College (1-4 or 5+) ansportation $\mathbf{B}_{\mathbf{e}}$ 17. Father's Name (First, Middle, Last) ပ impson 01 Ethel Johnson Relationship (Type, Prir own, State, Zip Code) 21239 orthern 1 Balto. ouplin Place of Disposition (A cemetery, crematory Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot . Page 1 : ■ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) . Signature of Funer: Survice License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final demented Jasculor Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): **To the Hospital or Attending Physician:** The law requires that the death certificate be executed Cause (Disease or injury and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the s should be detached 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{Yes} \) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be completely filled in by the 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 L Certifying Narse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. of certifie 29b. Signature and # 29d. Date signed (Month, Day, Year) f person who completed cause of death (Item 23a) (Type, Print) ORNBLUTE State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death MY7500 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2012 20° 12:56A M May Brian Leigh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville 9632 Mason Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Birthpiac Country) MD **Funeral** Hours Min 0672971969 Unk 42 Brian Leigh 05/20/2012 Maryland 21215-0036 Director 1 🛛 M 2 🗆 F Usual Residence of Decedent or items 23a or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director Parkville MD Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21234 9632 Mason Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black White etc Yes 2 No 1 Never Married 2 Married Completed by Specify: White 1 ☐ Yes 2 X No Specify: is marked other than "natural", 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Carpenter 12 17. Father's Name (First, M Fred Leigh 18. Mother's Name (First, Middle, Maiden Surname) Joy Ling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
18321 Maple Lane Ext Rawlings MD 21557 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tra once. . Page 1 and 2 s Mother Joy Harvey Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2X Cremation 3 Removal from State 05/25/12 Atlantic Crem Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of uperal Service Licensee ThomasAllen PA 7090 Ridge Rd Hanover MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Cother (specify) in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death signed by the a a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy perform death? 1 Yes 2 X No 1 ☐ Yes 2 ☐ No this certificate ospital or Attending Physician: hours after death. uneral Director: After this certific 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes ပ္ 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year)

05/12/2012

28b. Time of injury wor 1

28c. Place Injury - At home, farm, street, factory, office building, etc. (Specify) 28c. Injury at work? 1 ☐ Yes 2 No 28d. Describe how injury occurred Succide 27. Manner of Death Certificate: 28f. Louation (Street an Number or Rural Route Number, City or Town, State) 96 32 Mason Avenue Par Kuille MD 21234 5 Pending 1 Natural Accident Investigation 6 Could not be 3 Suicide determined Home To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basic of examination and/or investigation. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 018667 May 23, 2012 PM:1:tello, MD Trimble 4:11 CT. Luthenville, MD 21093 State MAY 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ : 25 PM 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nursing lizabeth timore 211 Sal If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗌 M 2 🖾 🗙 Days (Month, Day, Year) 1/18/1923 230-14-0339 Months Min. 89 **Director** Usual Residence of Decedent show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ms 23a or 28a-f sho must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore XX Yes 2 No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 21227 Funeral 3320 Benson Avenue ral", or items 23a Examiner must be USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2X No Maryland 21215-0036 White 1 Yes 2X No Specify: Specify: 3 X Widowed 4 Divorced Year or Dates item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Rebecca J. Shoop John Dickenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) er 8104 Sprague Dr., Pasadena MD 21122 Patricia A. Lightstein /Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of F Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 5/22/12 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sc 22 Name and Address of Facility Charles L. Stevens Funeral Home, Inc Victor P. Doda <u> 1501 E. Fort Avenue, Baltimore MD 21230</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ P men Medical resulting in death) Due to (or as a consequence of) **Examiner** oron Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the bunal-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by limidemia 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benson MI 3320 venue 2 g Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16694 Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Marie 05 Miranto 2012 2:02 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Ba<u>ltimore</u> <u>Towson</u> If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Director 213-03-3017 1 M 2 K F 91 01/06/1921 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford 1 Yes 2 K No Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1406 Bassett Court 21014 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Dominic Cellinese Algisa Cozzi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Toni Shinn, Granddaughter 160 Orville Road, Baltimore, MD 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Svc. Corp. 05/24/2012 Towson, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc Morandra 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): e Hospital or Attending Physician: The law requires that the death certificate be executed 1.24 hours after death.

Permeral Director: After this certificate has been signed by the attending physician and sletely filled in by the furneral director, page 2 should be detached for use as the burial-transit Cause (Disease of injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 N Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE |요 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work?
1 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Centifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) D0071287 5-23-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PWWP Challer, 67 of M. Challs St. \$4105, Balthmare, MD 21204 31. Date filed (Month, Day, Year) State MAY 29 Registrar

DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Keith Miller Robert 23 4:50 P May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dundalk Baltimore 1205 Hillshire Road Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** Months Days Hours 212-13-7330 Maryland **Director** 1 🕱 M 2 🗆 F July 24,1970 Vrs 41 Usual Residence of Decede 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Examiner must be notified at Director Dundalk 1 Yes 2 No Baltimore MD 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? items 23a 1205 Hillshire Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify "natural", Completed 3 Widowed 4 Divorced White other traumatic event, the Medical 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72. h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Carver Center Elementary/Secondary (0-12) College (1-4 or 5+) Robert Miller 6 Years Artist/Art Teacher Baltimore County 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Phyllis Knight George A. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carol Joy Miller (Wife) 1205 Hillshire Road Dundalk, Maryland item 27 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If it in my in ury or o once. cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 5/29/2012 Towson, Maryland Hilltop Service Corp. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Emeral Service License Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Asphyxia Ph_i_ian disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** could distly list our litters if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami and that initiated events resulting in death) Last Due to (or as a consequence of) physician ar s the burial-t Physician/Medical The law requires that the death certificate be Box 68760 as t attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ⊥ 9 ☐ Unknown been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2 No this certificate has 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Hospita Other: 2 🗆 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 C Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred u.C.de 28c. Injury at Certificate: 5 Pending 1 Natural 1 Yes 2 No 50P 12012 y Hangina Accident Investigation 3 Suicide 28f. Lo ation (Street and Imber or Rural Route Number City or Town, State) 1205/4:11/5hire 1000 d 6 Could not be ace of Injury - At home, farm, street, factory, office filled in by 4 Homicide determined building, etc. (Specify) Home Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number May 23, 201 2 (Type, Print) person who completed cause of death TrimbleHill 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DM Chester Joseph Madigan Medical 4a. Facility Name (if not institution, give street and number, own, or Location of Death 4c. County of Death **Examiner** Himor n/a 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 220-36-4004 1 🛛 M 2 🗆 F Yrs. 1940 71 Sept 5, Maryland Usual Residence of Decedent show 10b. County ä 10c. City, Town or Location Director must be notified 28a-f 1 🗌 Yes 2 💢 No Baltimore Maryland **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 능 Completed by Funeral 23a 21207 USA 1644 Forest Park Avenue ral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Yes, Give permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 🗆 Widowed 4 💢 Divorced White Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Claims Advisor Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental P ဂ of Health and Menta fitem 27 is marked rother traumatic e Chester Madigan Connor Michael Dorothy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael C. Madigan/Son 13466 Bidwell Court, San Diego, CA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of E Important: If ite any injury or oth Date 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 5/26/2012 Glen Burnie, Maryland Bryan W. Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 23a. Part 1. Exer the disease, or complica shock, or heart failure. List only one c ns that c sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer failure. List only one Immediate ause ()nal disease or onditi resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Cause (Disease or injury signed by the attending physician and dedetached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Year Month Pregnant at time of death 5 Other (specify) 1 ☐ Yes ≥ L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown After this certificate las t een si funeral director, pag 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **(**Vo ပ္ 1 🗌 Yes 1X Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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			for State C	f Maryland / Departme		Mental Hygien	e 2012	16697
			Registrar 1. Decedent's Name (First, Middle, Last)	Certifica	ate of Death	Reg. N	<u> 2 U I Z</u>	3. Time of Death
H	Physicia Medic		03 .1 11 7	enald			S ZOIZ	5,20 A M
)	Examin		4a. Facility Name (if not institution, give street and num		ity, Town, or Location of Death	ryland 4	c. County of Death	ore
	Funeral Director		5. Social Security Number 6. Sex 148-16-7015 1 M 2 F		der 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	9. Birthp	place (State or Foreign
	3	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location		2-14-19		10d. Inside City Limits
	Maryla 28a-f notified	Director	MD Baltimore	Catonsu				1 Yes 2 No
	with the	Funeral D	300 Maiden Choic	e Lane	21228	10g. C	itizen of What Cour • USA	ntry?
980	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Dece Armed Fo	2 1 No e 1 ☐ Ye:	cedent of Hispanic Origin? (Spe pecify Cuban, Mexican, Puerto s 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, 6 Specify: Black	
1215-0036	1 and 2 should be filed within 72 hour if Health and Mental Hyglene. item 27 is marked other than "natu other traumatic event, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Quilege (1	16a. Decedent's U (Give kind of life. DO NOT	work done during most of work use letired)	ing 16b. 1	Kind of Business/Ind	1
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Maryland	should be file and Mental H 7 is marked o raumatic eve	₽	Willie Lofton	(1.2)	Nia	nnie L	-otton	2420
	1 and 2 sho if Health and item 27 is r other traun	19	Claude He M. Brown		Chape Gar	e Ln. Ba	or Town, State, Zip C	mD 21229
Baltimore,	Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State 20b. Place of Disposition (I cemetery, cremativy of Cemetery)	Name of or other place)	Date 12 20c. I	Location - City or To	own, State
Balti	permit. Page Department o Important: If any injury or once,		21. Signature of Fune A Service Licensee	22. Va	alghass Cool Gree	ene fune	ral Ser	virces
			23a. Part 1. Enter the disease, or complications that of shock, or heart failure. List only one cause on ea	aused the death. Do not enter the moch line.	node of dying, such as cardiac of	or respiratory arrest,	au	Approximate Interval Between
5	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	ero sclero hc Ca	-diovasular o	disease		Onset and Death
100	Examiner	<u>.</u>	Sequentially list conditions, b.					
	e executed cian and vurial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events C.	or as a conse "uence o"]:				
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9289	eath certificate be a attending physici d for use as the bu	/Med	IF FEMALE: 23c If yes out	come of pregnancy				
. Box 68760	Hospital or Attending Physician. The law requires that the death certificate be 24 hours affer death. At the certificate be 12 hours affer death after this certificate has been signed by the attending physic stely filled in by the funeral director, page 2 should be detached for use as the b	Physician/Medical	in the past 12 months 2	Birth 2 Fetal death 3 Ectop nant at time of death 5 Other			23d. Date of delive Month	Day Year
P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to d	eath but not resulting in the underlying	ng cause given in Part I.	23e. Did tobacco	use contribute to th	ne cause of death?
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of Vital Records,	sician: The law re certificate has bi lirector, page 2 sh	Completed by				24a. Was an autopsy performed?	prior to co	psy findings available mpletion of cause of
tal	ysician: T nis certifica I director, p	Be C	25. Was case referred to medical examiner?	and see the second	26. Place of Death (Check		10 100	2 2 110
f Vi	Physic this or	မ	Hospital;	Inpatient 2 ER/Outpatient 3 Of Injury 28b. Time of		me 5 Residence)
o uc	Attending F death. ctor: After by the funer	icate		th, Day, Year) injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	iry occurred	
Division	ie Hospital or Attendir n 24 hours after death. ie Funeral Director: Af oletely filled in by the fu	Il Certificate:		of Injury - At home, farm, street, facing, etc. (Specify)	tory, office	28f. Location (Street a City or Town, State		Route Number,
_	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the base of the control of the characteristic of t		in my opinion, death occurred at	the time, date and plac	ce, and due to the car	use(s) and manner stated.
	To the Confidence of the Confi		29b. Signature and title of certifier Ann M. Batterwood,		29c. License number R 0 8 2 3 8 2	I .	ate signed (Month, I	
			CO. Name and address of severe who considered con-	- of doubt (them 000) (Time Drint)				
			Ann M. Butterworth	CRNP 709 maide	nchice Lane 1	saltimore,	ma di	220
	Stat Registra	te	31. Date filed (Month, Day, Year) 32. R	ecultrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year G McMullen 2:30 A M Mary MAY 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4327 Will Street Prince George's Capital Heights 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 **Funeral** 515 38 3618 1 🗆 M 2 🔏 F **Director** 74 April 25, 1938 Kansas Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Tes 2 No Capital Heights Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö by Funeral 23a United States 20743 4327 Will Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: If Yes, Give Year or Dates Specify: Black 3. Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit. Department of Health and Mental Hygier. Important: If item 27 is marked other any injury or other any injury or other any injury or other and in Services Par— Legal Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Minnie Watkins Louis Glenn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3614 Endsley Place, Upper Marlboro, MD 20772 Lori Jackson (Daughter) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Maryland Veterans Cemetery May 31, 2012 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ancreatic Cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Pregnant at time of death 2 No 9 Unknown 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 50057465 29b. Signature and title of certifier INSKY APARILIMO

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Baltiplace MOZIZO 9

address of person who completed cause of death (Item 23a) (Type, Print) 703

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Maggott 7:48 AM Dennis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** OF Maryland Baltimore Inversity If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 218-58-2651 **Funeral** Days Min Hours 60 **Director** 1 XM 2 - F 09/13/1951 Maryland 28a-f show 10d. Inside City Limits 10a. State 10c, City, Town or Location Examiner must be notified at Director 1 🗆 Yes 2 🛣 No Baltimore Middle River 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a United States Funeral 2104 Coralthorn Road 21220 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces Black, White, etc or P 1 Never Married 2 Married þ 1 ☐ Yes 2XXNo If Yes, Give Year or Dates. 72 hours after Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. should be filed within 72 hours afti and Mental Hygiene. is marked other than "natural", Completed 3 X Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing 12 Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Margaret Unknown or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 2104 Coralthorn Road, Middle River, MD Christina Maggott (dtr) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or otl 1 Burial 2X Cremation 3 Removal from State Glen Burnie, Maryland Altantic Crematory 5/25/12 4 Donation 5 Other (Specify) Charles S. Zeiler & Son, Inc. 21. Signat p of Funeral Se vice I 22. Name and Address of Facility 6224 Eastern Ave., Baltimore, MD 0 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween Onset and Death Immediate Cause (Final Physician Shock Septic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Muchoid Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and burial-tra Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be early hours after death.
Funeral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ signed by the atter Id be detached for in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Thrombountopenia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ₺ No 1 ☐ Yes 2 🔀 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 ☐ Yes 2 🗶 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1-Natural 5 Pending ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1124313374 5/23/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Santanii. Ca 22 South Greene street Nicholas

State Registrar Date filed (Month

Day

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Physician/ 181000m Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Curroll Hospita Westminse Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 216-32-2228 Director 1 🛛 M 2 🗆 F 76 Jan 26, 1936 Maryland 10b County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director be notified 28a-f 1 Yes 2 X No Eldersburg Carrol1 10f. Zip Code 10g. Citizen of What Country? ь 10e Street and Number items 23a Funeral 21784 U.S.A. 1731 Gemini Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian rmed Forces?

X Yes 2 No Black, White, etc. ò 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", idical Exar 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Goddard Space Flight Elementary/Secondary (0-12) College (1-4 or 5+) Logistics Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental Fitem 27 is marked o John Gregory McCarthy Wilamina Rausch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. McCarthy 1731 Gemini Drive Eldersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Carroll Cremation 5/29/12 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, Maryland 21. Signature uneral Se 22. Name and Address of Facility ice Licensee 11824 Reisterstown Road any Wayne Osterling ELINE FUNERAL HOME Reisterstown, MD e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between 23a. Part shock, or heart failur Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Blueered Medical Examiner Sequentially list conditions. Examiner as a consequence of If any, leading to immedicause. Enter Underlying Cause (Disease or injury Advunced that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Ascites Hypoalbumenene Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: Certificate: To 1 ☐ Yes 2 No 1 Name Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury Natural 5 Pending Accident
Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours are.

To the Funeral Direct 4 Homicide determined Certifying Physician: To the best of my Medical Examiner: On the basis of exam eath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier lowledge, nivestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of e 3 Certifying Nurse Plactitioner: To the e best of my know 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cau 23a) (Type, Print) State MAY 29 Registrar

HMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	Otate or ivial years	•	tificate of L		Reg.				
	Physicia		1. Decedent's Name (First, Middle, Las James Albert Mull					2. Date of Death Month May 27	ZU 7, 2012	3. TimeOf Death 3:27 A.M		
	Medic Examin		4a. Facility Name (if not institution, give	,		_	r Location of Death	LLY Z	4c. County of			
المسيد	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9	Birthplace (State or Foreign Country)		
	Director		541–46–7877 Usual Residence of Decedent	₹ м 2 □ F 70	Yrs.	Worlins Days	TIOGIS TIVIII.	Dec. 03, 1		Raleigh, N.C.		
	Maryland 28a-f shor	Director	Maryland Baltimo		, Town or Loc OWSON	cation				10d. Inside City Limits 1 ☐ Yes 2 🌁 No		
	h with the	Funeral D	10e. Street and Number 307 Donegal Drive	:			21286		Citizen of What United			
3036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. Is marked other than "hatural", or items 23a or 28a-f show ther traumatic event, the Model Experience must ken citified at other traumatic event, the Model	ρ	11. Marital Status 1 □ Never Married 2 ♣ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.		Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 KNo	ispanic Origin? (Spe in, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)		American Indian, White, etc. White		
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and 2	be filed wi ental Hygie ked other ic event, II	To Be (17. Father's Name (First, Middle, Last) James Albert Mull		PIOL	essor or		(First, Middle, Maid		ia, Berkeley		
lary	should be file n and Mental I 7 Is marked o raumatic eve		19a. Informant's Name/Relationship (7)			_	and Number or Rura			· · · · · · · · · · · · · · · · · · ·		
ē,	1 and 2 of Health item 27 other tr		Jacqueline (nee No 20a. Method of Disposition	20h P	lace of Dispos	sition (Name of	negal Driv		 -	and 21286		
Baltimore, Maryland	permit. Page 1 Depertment of Important: If it any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State (Fval)	s'Funer mation S	al Clatel a ervices, In	May 2	3.2012 F	brest Hi	11.Marvland		
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~ .	hysician/ Medical Examiner		23a. Part 1. Inter the disease, or come shock, or hear failure. List only of Immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on each line. a	Int	er the mode of dyin	g, such as cardiac c	r respiratory arrest,	Chroni	Approximate Interval Between Onset and Death		
	ed ssit	Examiner	Sequentially list conditions, if any kinding to immediate cause. Inter Underlying Cause (Disease or injury)							21		
	cate be executed physician and s the burial-transit	cal Exa	that initiated events resulting in death) Last	C. Due to (or as a consequ	ence of):							
8760	rificate ing phys e as the	Medical I	IF FEMALE:	d					1			
Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	by Physician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1 Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3 🗌	Ectopic pregnand Other (specify)	су		23d. Date of Month			
ls, P.O.	uires that the signed by ald be deta		Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderlying cause gi	ven in Part I.			o use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☑ Únknown		
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ital	ysician: is certific director,	Be B	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	50.0	Oth	ace of Death (Checker:	only one)				
Division of Vital	Hospital or Attending Physician: 24 hours after death. Funeral Director, After this certifica	Certificate: To	27, Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	ent 3 □ DOA 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) → C			Specify) HCS (S) C			
Divisi	pital or Att burs after d eral Directo filled in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hos building, etc. (Specify)	me, farm, stre	eet, factory, office	ry, office 28f. Location (Street and Number or Rural Route Number City or Town, State)			r Rural Route Number,		
	To the Hospi within 24 hou To the Funer completely fill	Medical	(Check 2 ☐ Medical Examonly one) 3 ☐ Certifying Nur	sician: To the best of my knowle iner: On the basis of examination se Practitioner: To the best of m	and/or invest	igation, in my opinio	on, death occurred at	the time, date and pl	lace, and due to	the cause(s) and manner stated.		
	North Con		29b. Signature and title of certifie			29c. Licenso		29d.	Date signed (M	Month, Day, Year)		
	ĎV		30. Name and address of person who	completed cause of death (Item	23a) (Type, P	rint)	046		5/24	115		
	Stat	te	31. Date filed (Month, Day, Year)	G 70 N Clu 32. Registrar's Signat	aulis.	28 72	ite 4105	Baltin	Love	MD		
	Registra	ar	MAY 2 9 2012 Den	may 18. 19								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760
the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death
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	1 _ State	Indelible Ink. Ensure Apartment of Health and Nertificate of Death	Mental Hygiene 2 (_{jible} .) 12 - 16702
Physician/ Medical	1. Decedent's Name (First, Middle, Last) Richard Lee Martin	ertinicate of Death	Reg. No. 2. Date of Death Month Day A 2 4	3. Time of Death Year 2:14 PM
Examiner	4a. Facility Name (if not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death Baltimore	4c. County	of Death N/A
Funeral Director	5. Social Security Number 220-14-2736 Usual Residence of Decedent 6. Sex 1 🔀 M 2 🗆 F 7. Age (In yrs. last birthda) 7 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) July 30,1923	9. Birthplace (State or Foreign Country) Baltimore, MD.
Maryland 28a-f sho otified at	10a. State 10b. County 10c. City, Town or Baltime			10d. Inside City Limits 1 Yes 2 □ No
items 23a or 28a-f sho er must be notified at Euneral Director	10e. Street and Number 102 Ridgewood Road	10f. Zip Code 21210	10g. Citizen of V Uni.t e	What Country? ed States
in y	1 Never Married 2 Married 1 Never Married 2 No Active	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify:	cify Yes or No- Rican, etc.) 14. Rac Blac Specify:	e - American Indian, ck, White, etc. White
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other the ent, the Be Co	17. Father's Name (First, Middle, Last)	Assembly Line Worke	e (First, Middle, Maiden Surname	eral Motors
narked natic ev	George Harvey Martin, Sr.	Helen Ca	ulfield	
alth and		ailing Address (Street and Number or Rura 2 D Swarthmore Dri		State, Zip Code) aryland 21204
ient of He nt: If iten ry or oth	1 Kurial 2 Cremation 3 Removal from State Cemetery, C. 4 Donation 5 Other (Specify)	idge Cemetery Med	30 2012 Park 1	Limore County) Heights, Maryland
Departm Importa any inju once.	21. Signature of Funeral Services Leffrey L. Gair, Sr. GSP	22 Name and Address of Facility S 1 2225 York Road Tim	Juneral and Crement	ion Center, P.A. 21093-2215
attending physician and attending physician and lfor use as the bural-transit are as the bural-transit cian/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Declusion		Onset and Death	
within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but may be the funeral director. Medical Certificate: To Be Completed by Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 1	□ Ectopic pregnancy □ Other (specify)	23d. Dai	te of delivery nth Day Year
been signed by the atte should be detached for leted by Physicia	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		ibute to the cause of death?
s certificate has been si director, page 2 should o Be Completed			autopsy performed? 1 ☐ Yes 2 No	Nere autopsy findings available prior to completion of cause of death?
nis certifi Il director To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 npatient 2 ER/Outpat	26. Place of Death (Check ient 3 DOA Other: 4 Nursing Ho	only one) me 5 Residence 6 Other	er (Specify)
after death. Director: After the fine by the funera Certificate:	27. Manner of Death 1	work? M 1 ☐ Yes 2 ☐ No	28d. Describe how Injury occurre 28f. Location (Street and Number City or Town, State)	
in 24 hours at he Funeral D pletely filled i	29a. Certifier 1	h occurred at the time, date and place, an	nd due to the cause(s) and mann	er as stated.
within 24 To the F complete	(Check 2 Medical Examiner: On the basis of examination and/or invonly one) 3 Certifying Nurse Practitioner: To the best of my knowledday. 29b. Signature and the of certifier	ge, death occurred at the time, date and pla 29c. License number	ce, and due to the cause(s) and m	
<u>, </u>	30. Name and address of person who completed cause of death (Item 23a) (Type		- ','	4012
State	Matthew Melo 201 E. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	University Yark	way, Baltin	ore, MD 21218
Registrar	NAY 2 9 2012 Jenne . B. parls			

DHMH 17 Rev 06-2011

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

_	1 - State Registrar					C	Certifica	te of L	Death		F	Reg. No.	20	12		5									
	^	ame (First, Middle,	4	, -				_			ate of Dea	th Day	20	Year	3. Time o) De									
n il	Kose M Man Sill As Earlith Name (If not institution give street and number) 4b City Town or Location of Death 4c County of Di									12	17:0	0 (
r	U stay, temperature of the stay of the sta																								
	Johns Hopkins Bayview Medical Center S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Example 1.									9. Birtho	lace (State	or F													
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical **Examiner** If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Hours 230-28-7075 1**X** M 2 □ F **Director** Virginia July 5,1925 86 show 10d. Inside City Limits 10c. City, Town or Location 10a, State 72 hours after death with the Maryland at Director ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 No Baltimore City Maryland 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? United States Funeral 1637 Ceddox St. 21226 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces 2 Black, White 1 Never Married 2 Married 2 White Baltimore, Maryland 21215-0036 1 Ves 2XXNo "natural", Completed 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me life, DO NOT use retired) College (1-4 or 5+) N/A Elementary/Secondary (0-12) 7th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mullins Ethel Laverne Leonard Everett Mullins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1637 Ceddox St., Baltimore, Maryland 21226 Loretta Johnson / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2XXCremation 3 Removal from State Atlantic Crematory May 27,2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signal of Fyle Service Licensee 22. Name AMBROSE FUNERAL HOME OF LANSDOWNE anni 2719 Hammonds Ferry, Rd., Lansdowne, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between set and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: for use s, outcome of pregnancy Live Birth 2 - Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe has death? certificate Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ည Impatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at 27 Manner of eath 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work 1 Tyes 2 🗌 No ieral Director: At filled in by the fu Investigation Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Ye

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death led way Month Physician/ 2,03 PM DUVNY Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Bultimore 3a Multicerre Cer 6. Sex 7. Age (In yrs. last birthday) If Under Date of Birth 9. Birthplace (State or Foreign Number **Funeral** (Month, Dav. Year) Hours Min 165-01-5335 Director 1 🛛 M 2 🗆 F 11/30/1918 PA 93 28a-f shov 10b. County 10d. Inside City Limits items 23a or 28a-f shoner must be notified at I Oa. State 10c. City, Town or Location Director 1 🗌 Yes 2 🕱 No MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 4 CANDLEMAKER COURT, #201 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced WHITE Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the CHILDREN'S CLOTHING BUYER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ GRIPMAN LOUIS **MEDWAY** FANNIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau once, COLLEEN S. MEDWAY/WIFE CANDLEMAKER COURT. #201, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 XBurial 2 Cremation 3 X Removal from State SHALOM MEMORIAL PARK 05/29/2012 LOWER MORELAND, PA 4 Donation 5 Other (Specify) ture of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1 Enter the disease, or complication at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ Ra disease or condition resulting in death) Medical Due to (or as a consequence of 415 **Examiner** canc Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ After this certificate has been signed by the atter funeral director, page 2 should be detached for in the past 12 months? Month Year Day Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by weter 100 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2. No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 \square Yes 2 🗌 No Accident Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Scrifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 6 death (Item 23a) (Type, Print) ompleted cause N. Charles of Bulto MD 2/204 CR Jartur 6701 SBMC 32 State

Registrar

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To a State 10b. County 10c. City, Town or Location 10d. Inside City 1 Yes 2 10b. Specify 10b.	543 1 M 2 F 33 Yrs. Months Days	Hours Min. Nov. 21, 1978 Country Maryland
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21. Signature of Funeri I rivice Licenses 22. Name and Address if Facility 3332 Frederic Are Buttmer Maryana 3332 Frederic Are Buttmer Maryana 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head a. Hypertensive Cardiovascular Disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter threating in death) Due to (or as a consequence of): AMENDED 23a, 27, per me, g930 8-9-12 sm	Cremation 5 Nemoval mon state Metro Created and	5/29/12 Catonsville, Maryland
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failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): AMENDED 23a, 27, per me, g930 8-9-12 sm	ijsease or complications that caused the death. Do not enter the mode of dying, such	h as cardiac or respiratory arrest, shock, or hear
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): AMENDED 23a, 27, per me, g930 8-9-12 sm	one cause on each line.	Petween Onset and
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AMENDED 23a, 27, per me, g930 8-9-12 sm Section Sec		2
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Yes 2 No 9 V Unknown The standard of the st	agnant in the 1 Live birth 2 Fetal death 3 E	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death of the conditions	Ole Halvaura	
Yes 2 No 3 Probably 4 ♥ Oliving Sava an autopsy performed? 1 ▼ Yes 2 No 3 Probably 4 ♥ Oliving Sava prior to completion of cause death? 24a. Was an autopsy performed? 1 ▼ Yes 2 No 1 ▼	ant conditions contributing to death but not resulting in the underlying cause given	
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examiner? Hospital: 1	No The state of th	
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2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 27 Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 27 Town, State)	Investigation 28e Place of Injury - At home farm street factory office huilding	
O signated by the part of the	_ , , , , ,	of Town, State)
27. Manner of Death 1	dicel Exeminer: On the basis of examination and/or investigation, in my opinion, dea	
and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)		umber 29d. Date signed (Month, Day, Year)
Theodow M, Kird JRenny) O.C.M.E. OCME May 23, 2012	on My Ring JReamy	E. OCME May 23, 2012
30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223		e Street, Baltimore, MD 21223
State State Registrar 11. Date filed (Month, Day, Year) Registrar 12. Registrar's Signature	Day, Year) 2. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mav Month Arthur Guy Naill Jr 2012 7:02 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days **Director** 1 🛛 M 2 🗆 F 215-34-8935 75 Mar. 30, 1937 Maryland Usual Residence of Dece 28a-f shov 10b. County ral", or items 23a or 28a-f shor Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Mt. Airy Maryland Frederick 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral U.S.A. 14102 Peddicord Rd. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 er than "natural", c , the Medical Exam 1 Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) plastic products mfg. 12 warehouse manager other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Bernice Shifflett Arthur G. Naill Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mt. Airy, MD 21771 Ruth Naill/ wife 14102 Peddicord Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State All County Cremation 5/28/2012 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 21. Sig tule of Funeral Service Licenses 22. Name and Address of Facility Hartzler Funeral Home, P.A. affarina 11802 Liberty Rd. Libertytown, MD Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death mmediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine Due to for as a consequence off cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of): sician Physician/Medical phys the t Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nhknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy nas Yes 2 N 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 KNO Other: 1 🗌 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ rpatient 2 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1
Yes 2
No Natural Accider 5 Pending Investigation Accident within 24 hours after death

To the Funeral Director;

completely filled in by the Suicide 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 0016428

DHMH 17 Rev 06-2011

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2012

2 III 300 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05 Physician/ 12:05 AM WILLIAM NOT Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** BALTIMORE SAMARITAN 405P11711 9. Birthplace (State or Foreign Year If Under 24 Hrs. 8. Date of Birth If Under 1 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 03/19/1961 219-80-3340 Maryland 51 **Director** 1 X M 2 □ F "natural", or items 23a or 28a-f show idical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2XXNo Towson Maryland Baltimore 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 21286 Funeral 222 Linden Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. If Yes Give White 3 Widowed 4 Divorced Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Construction Laborer Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara Utz ဂ Joseph Noto should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 Linden Avenue Towson, Maryland 21286 Sister Victoria L. Noto Page 1 and 2 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, nent of Important: If B any injury or c 1 Burial 2 X Cremation 3 Removal from State Hanover, Maryland Ardent Cremation Inc 05/21/2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, Signature of Funeral Service Licensee 6009 Harford Road Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or compressions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ HYPERCANNIC KESPINATOM ALLIE HYPOXIC MINUTES resulting in death) Medical Examiner NERO MZING PNEUMONIA 50 DAYS Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician the deria Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? the Hospital or Attending Physician: The law requires that Completed by 1 Tes 2 No 3 Probably 4 Inchrown DIMBETES MELLITUS, CHRONIC ALCOHOL 24 hours after death. e Funeral Director: After this certificate has been signated by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an MOUSE. LATSTYCINTESTINAL BLUEDO performed CLOSTRIBIUM DIFFICILE COLITIS 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: i 🖊 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25310 MD 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) MO 2122 J080N 5601 LOCH PAVEN BOULEVAND BALTIMENTE TANNIA

DHMH 17 Rev 06-2011

Registrar

Date filed (Month, Day, Year)

MAY 2 9 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Freddiesowens 登:150 Main Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Season's Hospice Randallstown **Baltimore** If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 164-36-1854 Director 1**XX** M 2 □ F 65 July 11, 1946 MD Usual Residence of Deceder permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 XXes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1235 Dellwood Avenue 21211 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 1971 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within 72 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Track Worker Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Clayton Clifford Owens Retha Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Owens (Wife) 1235 Dellwood Avenue Balto, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXX Burial 2 Cremation 3 Removal from State 5/31/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. Signature of Funeral Service) 3631 Falls Road BAlto, MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final End-Stage Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or injury and -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician at for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the 9 Unknown þ Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b, Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s performed? Yes 2 No this certificate 2 No 1 🗌 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? □ Nursing Home 5 □ Residence 6 □ Other Specify ent houp (4 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending nours after death. neral Director: Aft filled in by the fur Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MSRAY UP WINEMID D0057465 5/24/12

Registrar

Smith AV

203 Baltimore MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

NS Rajapakse MD

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** a^{M} 25, 4:17 2012 May R. Owings Clinton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westminster Carroll Carroll Hospital Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 🕱 M 2 🗆 F Mar 24, 1918 Maryland Director 217-01-3883 94 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location Show 10a, State iral", or items 23a or 28a-f shov Examiner mast be notified at 1 ☐ Yes 2 🖾 No Reisterstown Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. Apt 312 21136 306 Cantata Court Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? within 72 hours after ⊠Yes 2 □ No FYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. ģ 3 XWidowed 4 ☐ Divorced White Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) than, s 1 and 2 should be filed within the Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Repair Service Furniture 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be D. Rawlings Mary Owings Charles ۵ other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Reisterstown, Maryland 21136 14916 Dover Road Darlene O. Schultz Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Reisterstown, Maryland 5/30/12 All Saints Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Funeral Service Licensee ELINE FUNERAL HOME Reisterstown, MD 21136 zen Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death)) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner emen and burial-tran Due to (or as a consequence of): Box 68760. attending physician certificate be Physician/Medical the as IF FEMALE: ase ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy jo Month Day Year Pregnant at time of death 5 Other (specify) □Yes 2□No P.O. the detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 Probably 4 Unknown 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 🎤 Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes ၉ this funeral 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Deatl 28b. Time of 28c. Injury at Work? Hospital or Attending P 24 hours after death. Funeral Director: After t After Certification: (Month, Day, Year) Injury 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, 29c. License number 29b. Signature and title of certifier

State

State 31. Date filed (Month, Day, Year Registrar

30. Name and address of person who completed cause of death (Itel

32. Registrari Signature

oppa Kd #

5/25/12

01 # 20

Lutherville, and 2109

23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **243** A M 2. Date of Death Day Month Year Physician/ PATTERSON CASSANDRA R MAY 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMONE SECOURS HOSPITAL Age (In yrs, last birthday)

54 Yrs. If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 219-68-1575 Months Days Hours Mir 1 DM 2 W Director Usual Residence of Decedent 23a or 28a-f show 10b. County aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director timore be notified 1 Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral with Voodington 1229 traumatic event, the Medical Examiner must "natural", or items hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status vas Decedent Ever in U.S 14. Race - American Indian, Armed Forces' Black, White, etc. þ 1 Never Married 2 Married 2 No 1 Yes 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation eaents Usual Occupation
wind of work done during most of working
DI NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) within 72 al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) ashier Be Maryland and Mental F Liams pe I and 2 should b f Health and Mer item 27 is mark Informant's Name/Relationship (Type, Prilitaughter) ND 21208 203 Department of Health
Important: If item 2
any injury or other t Baltimore, 20b. Place of Disposition 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Itimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. SEPS15 disease or condition Medical resulting in death) Examiner PNEUMONIA Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate MYELOMA or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events MULTIPLE Due to (or as a consequence of) resulting in death) Last burial physician the burial Physician/Medical Box 68760 attending IF FEMALE Ise 23d. Date of delivery 23h. Was decedent pregnant in the past 12 months? for Month Day Year 1 Yes 2 No been signed by the should be detached g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed Yes 2 No certificate After this certific funeral director, 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital: 2 🗹 No 1 Tes ည 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending work? 1 Yes 2 No in 24 hours after deam.
The Funeral Director: Aft Accident 🔲 Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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THOMAS 31. Date filed (Month, I BON SECOMS

HOSPITAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0538 AM Ε. Parks Carl OIA Medical Facility Name (if not institution, give street and number City, Town, or Location of Death Examiner 4c. County of Death Bultimore If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Min Hours Director 219-44-8535 1 **X** M 2 □ F 67 March 17,1945 MD show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 Cantata Court Apt 21136 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. Completed by 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced White Year or Dates stient howen as permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 U S Postal Service Letter Carrier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ F. Parks Marion Steffe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greg Parks Glyndon Drive, Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other placel 5/22/12 Carroll Cremation Hampstead, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road ·Wayne Eline Funeral Home Reisterstown, MD 21136 t ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between · heart fai List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by sate has been signated bage 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an UN autopsy performed 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: ဂ္ ER/Outpatient 3 DOA Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifier ٥ 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's signatu State 2 9 2012 Registrar

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		Registrar 1. Decedent's Name	e (First, Middle	e, Last)			Cer	uncat	e oi L	Jean -	2. Date of D			3. Time	of Death
Physicia: Medic		SOLBER	Γ			P	ERMUTI				Month MAY	23	, 201	2 11:3	0 A M
Examin	er	4a. Facility Name (if		-						Location of Deat	า	40	c. County of Dea	ath	
Funeral		830 W. 40TH STREET, #114 5. Social Security Number 6. Sex 1 X M 2 D F 7. Age (In yrs. last				ast birthday)	If Unde	r 1 Year	IMORE			N/A 9. B	irthplace (State	or Foreign	
Director		422-16-7 Usual Residence of		1. X .J M 2	□F	87	Yrs.	Months	Days	Hours Min.	03/0	5/19	25	ountry) AL	
and show	tor	10a. State	10b. County			10c. City	, Town or Lo	cation						10d. Inside (,
Mary 28a-f notifie	irec	MD					BALT	IMOR		<u>-</u>				es 2 🗌 No	
with the	Funeral Director	10e. Street and Number 830 W. 40TH STREET, #114						10t. ZI	p Code	1211		10g. C	Citizen of What C	Country?	
items er mu	Fune	11. Marital Status	40111	12. Wa	s Decedent ned Forces?	Ever in U.S	S. 13. \	Was Dece	dent of Hi	ispanic Origin? (S in, Mexican, Puerl	pecify Yes or No	-	14. Race - Am		
1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by	1 ☐ Never Marr 3 🔯 Widowed		ried 1.4. If Yo	Yes 2 Ces, Give				_	Specify:			Black, Wh	WHITE	
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shou h and 7 is m traum		19a. Informant's Na			t)					and Number or Ru					
f Healt item 2 other		THOMAS 20a. Method of Disp	position			20b. P	lace of Dispo	sition (Na	me of	DREAM LA	Date COL		A, MD Location - City of	21044 or Town, State	
Page ment o ant: If ury or		1 Donation			al from State	HIL	emetery, crer. LTOP S			ORP 05/	25/2012		TOWSON,	MD	
permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Fu	neral Service	icensee	-								N & BRO		
40100	_	23a. Part 1. Enter t	the disease, or	r complications	s that cause	d the deat				TERSTOWN ig, such as cardiae			SVILLE,	Approxim	
Physician/		shock, or hea Immediate Cause (disease or condition	rt failure. List (Final	only one cause	on each lin	e				sal Ca				Onset and	d Death
Medical Examiner		resulting in death)		a	Due to (or as	a consequ	ience of):	a v es j		1.000		772-		1	
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re deat the at ched fo	ysic	In the past 12 months? 1							WOITH		Teal				
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equires een sig ould b	ted	Chron	a con	+ h.R.T.	S	/ /	20 (2 No 3 □		
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ding P. h. After t funera	:ate:	27. Manner of Deat 1 Natural 2 Accident	5 Pendi	ng	Month, Da		28b. Time of injury	f M	28c. Injur work 1 □	y at <br IYes 2 □ No	28d. Describe	how inju	ury occurred		
Atten er deat ector: by the	Certificate:	3 Suicide 4 Homicide	6 Could		Place of In		me, farm, str				28f. Location City or To		and Number or F	Rural Route Nur	nber,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu			1976												
e Hosp 24 ho Fune leted fi	Medical	(Check 2	2 Medical	Examiner: On	the basis of	examinatio	n and/or inves	itigation, ir	my opinio	e, date and place, on, death occurred ne time, date and p	at the time, date	and plac	ce, and due to th	e cause(s) and r	nanner stated
To the vithin To the comp	2	29b. Signature and			2	, , , , , , , , , , , , , , , , , , , ,	,			e number		29d. D	ate signed (Mor	nth, Day, Year)	
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D		30. Name and addr	-	TONIN	10 1	550	23a) (Type, F	Print)	s B	41121	010	3/1	411100	MP	2.1224
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Registra	ali	1111		/4	-	10.	1								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5/9/12 Day Mercedes Rolfe Μ. 1:15am™ 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1493 Ascot Drive Pasadena, MD Anne Arundel Social Security Number 098–20–2364 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) Hours Months 83 1 M 2 XX 9/24/28 NY 10d. Inside City Limits 10a. State 10c. City, Town or Location MD Anne Arundel 1 🗆 Yes 💥 No Pasadena 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1493 Ascot Drive 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married White If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Law Legal Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emmanuel Pedraza Dolores Sanchez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy L. Wengert /Daughter 671 209th Street, Pasadena MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5/12/2012 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Victor P. Doda Name and Address of Facility Darles L. Stevens Funeral Home, Inc. 201 E. Fort Ave, Baltimore MD 21230

permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or amy injury or other traumatic event, the Medical Examiner must be a once. Baltimore, Maryland 21215-0036 Physician/ Medical **Examiner** burial-transit signed by the attending physician Id be detached for use as the burial the Hospital or Attending Physician: The law requires that the death certificate be nin 24 hours after death. Division of Vital Records, P.O. Box 68760 this certificate has been sirral director, page 2 should

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Medical

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	23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one	ications that caused the death. Decays on each line	o not enter the m	node of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	Ca veus	uma			Offset and Death
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amin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequent	e oi).			_	
calEx	resulting in death) Last	Due to (or as a consequent	ce of):				
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Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3 🗌 Ectop	oic pregnancy (specify)		23d. Date of o	lelivery Day Year
ed by Pr	Part II. Other significant conditions con	ntributing to death but not resulting	ng in the underlyi	ng cause given in Part I.			to the cause of death? Probably 4 Unknown
complet					24a. Was an autopsy performe	d? prior to death	autopsy findings available o completion of cause of cess 2. M No
Be	25. Was case referred to medical			26. Place of Death (Che	eck only one)		
10	examiner? 1 Yes 2 o	lospital: 1 ☐ Inpatient 2 ☐ ER	Outpatient 3	DOA Other: 4 Nursing I	Home 5 Residence	e 6 Other (Sp.	ecify)
Certificate:	27. Manner of Death 1 National Side Pending 2 Accident Investigation	(Month, Day, Year)	b. Time of injury		28d. Describe how injury occurred		
Certif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, fac	tory, office	28f. Location (Stree City or Town, S		Rural Route Number,
Medical	(Check 2 Medical Examin	ician: To the best of my knowledger: On the basis of examination are Practitioner: To the best of my	d/or investigation	, in my opinion, death occurred	at the time, date and p	lace, and due to th	e cause(s) and manner stated.
	29b. Signature and title of certifier			29c. License number	290	. Date signed (Mo	nth, Day, Year)
	1 1 1 1 1 1	A 11 N		DORACE		-11-1	2 - / 3

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Kobinson James 4:30 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death ave Baltimore If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 11-3-1949 If Under Birthplace (State or Foreign Country) **Funeral** 1 Year 1 **X**M 2 □ F Days Min. Hours 216-52-476 Director Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 28a-f Baltimore 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n Funeral South GAST USA 21224 items , 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō 1 Never Married 2 Married þ 2 🔀 No Ves Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify Specify: BUACK "natural" Completed 3 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) BALTO CITY permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Ireatment WATER WORKS Be 17. Father's Name (First, Middle, Last) မ 9a. Informant's Name/Pelationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brother 40 OBINSON GILLAND Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory ☐ Burial 2 Cremation 3 ☐ Removal from State BAZTIMORE, MD 4 Donation 5 Other (Specify) REENMOUNT GREENE FUNERAL SUS 22. Name and Address of Facility AUGHN 4905 ORK 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit the attending physician and the defendence of the street of the second sheet of the second se Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ retail ☐ Pregnant at time of death ☐ Unknown 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No be detached for Month 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an after death.

Director: After this certificate has autopsy death? Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann f Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred $5 \square$ Pending Natural work? 1 Tyes 2 🗌 No 2 Accident
3 Suicide
4 Homicide completed filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral E Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year 05 25 d address of person who completed cause of death (Item 23a) (Type, Prin Road MD 81234. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Physician/ 01:42 AM anzino Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death North Arundel Health & Rehab. Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 220 03 9620 **Director** 1 X M 2 □ F 09/25/1920 Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 313 Phelps Avenue 21061 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 Xio Black, White, etc. ò þ 1 X Never Married 2 Married Maryland 21215-0036 "natural", If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Aero-Space Electrician and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Peter J. Ranzino Florence V. Kemp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Donald T. Kemp (nephew) 1531 Waterbury Road Crownsville Maryland 21032 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) <u>Hill Cemetery</u> 5/30/2012 Brooklyn Park, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA of Fune. Service Licensee any 1407 Old Eastern Avenue Essex Maryland 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one basse on each line. Approximate Onset and Death Immediate Cause (Final ispase Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a Hospital or Attending Physician; The law requires that the death certificate be executed physician and sthe burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending physical at the ast IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death signed by the a 2 No g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ mer Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: 1 🗌 Yes ျ 1 Inpatient 2 X ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signat D005604

Registrar

DHMH 17 Rev 06-2011

4 210. Glen Burnie.

Name and address of person who completed cause of death (tem 23a) (Type, Print)

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Gene Rubenstein 05/24/2012 05:40a ^M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Future Care Irvington Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🗓 F Months Days Hours Director 83 IInk 06/06/1928 Wash D.C. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at MD Director Baltimore 1X Yes 2 □ No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 22 South Athol Avenue 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 <u>6</u> 1 ☐ Yes 2 XNo Specify: White 3 ₩ Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaker <u>3 yrs</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Ringwald Nora Juday 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau Edith Mountjoy 4509 Elmwood RD Beltsville MD 20705 Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buria! 2 🌠 Cremation 3 ☐ Removal from State Atlantic Crem 05/26/12 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie MD 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of Funeral Service Licensee ThomasAllenPA 7090 Ridge Rd Hanover MD Mones 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Due to (or as a consequence of): Examiner -OTOVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of or Attending Physlcian: The law requires that the death certificate be executed burial-transit Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 ☑ No 1∐Yes 2⊟No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) NAY 2 9 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

UZO UNEGBUIMO

22 S. ATHOL AVE BACAMORE, MD

11110

29c. License number

29d. Date signed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #1 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 2012 11:15A M FRANCES RICHMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GILCHRIST HOSPICE CARE TOWSON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Hours Min (Month, Day, Year) Country) 286-09-5065 Director 1 M 2 X F 90 10/09/1921 OH Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f sho Examiner must be notified at the Maryland Director 1 ☐ Yes 2 🕅 No BALTIMORE BALTIMORE MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21208 USA 49 GREENWICH PLACE death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. permit, Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin once. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: WHITE 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) JEWISH EDUCATOR EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ LAKRITZ PATER FANNIE 19b. Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PHYLLIS KLINE/DAUGHTER 24 ROLAND COURT, TOWSON, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BETH EL MEMORIAL PARK 05/25/2012 RANDALLSTOWN, MD anne of Funesa Sanaca Lucrisee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ Debility disease or condition Medical Due to (or as a consequence of): Examiner Respiralory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav Other (specify) Pregnant at time of death been signed by the s should be detached a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an Were autopsy findings available filled in by the funeral director, page 2. prior to completion of cause of death?

1 Yes 2 No autopsy Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 K Other (Specify) 2 1 🗌 Yes 2 📈 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 14 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours at To the Funeral D completely filled i Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of cert 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) MD D72139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Quile 4105 Baltimore 6701 Charles 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 6:10P Physician/ onia Medical a. Facility Name (if not institution, give street and n, or Location of Death **Examiner** unty of Death orien mbia Social Security Number 9. Birthplace (State or Foreign Country) If Under 1 8. Date of Birth **Funeral** Months 217-20-1262 1 □ M 2 🗹 (Month Day, Y Director Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City Town or Location 10d. Inside City Limits Director r 28a-f sh notified a olumbia 1 Yes 2 No 10e, Street and Number 10g, Citizen of What Country? items 23a or ner must be r 21044 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 0 þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: 3 ₩Widowed 4 □ Divorced Completed **B**lac traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NDT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ales Be 18. Mother's Name (First, Middle, Maig ျှ 19a. Informant's Name/Relationship (Type, Print) 2 ashina injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee ard acount Address of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ PELVIC MASS disease or condition resulting in death) MONTHS Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leaving to immediate cause. Enter Underlying Due to (or as a consequence of, attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? tor: After this certificate has been signed by the atter the funeral director, page 2 should be detached for Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by END STAGE DEMENTIX 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 DYSPHAGIA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician; The law within 24 hours after death.

To the Funeral Director, After this certificate has I autopsy HYPERTENION performed Yes 2 death? 3 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗖 No ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by 4 | Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

Registrar

State

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0069962

6334 CEDAR LANE, LORIEN, COLUMBIA, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State			State of M	arylan		artment of I		nd Menta	al Hyg	iene	;		
			Registrar 1. Decedent's Name	(First Midd	la (ant)			Cei	tificate of I	Death	0.5		leg. No	201	2	572
	Physicia Medic			Eve	lyn	Stepha	anie	Stap	les			ite of Deat onth ay 22		2012 Year	3. Time 7:45	of Death
	Examir	er	4a. Facility Name (if t			,			4b. City, Town, c				4c.	. County of Dea		
محرريوه	Funeral		Dacota B 5. Social Security Nu	road (Cree 6. Sex	k Assiste		ving ast birthday)	If Under 1 Year	Whitefo		te of Birth		Harf	ord thplace (State	e or Foreian
	Director	П	217-36-88 Usual Residence of I	372		М 2 💢 F	80	Yrs.	Months Days			on <i>th, Day,</i> ruary	23,	1932 Was	hingto	on, D. C.
	/land f show d at	ţo	10a. State	10b. County	/		10c. City	y, Town or Lo	cation						10d. Inside	
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	tems er mu	Funeral	11. Marital Status	4411		12. Was Decedent	Ever in U.S		Was Decedent of H	lispanic Origin	n? (Specify Ye	s or No-		14. Race - Ame		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Marrie 3 🏋 Widowed 4			Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.	No		f Yes, specify Cub I ☐ Yes 2 🛛 No		Puerto Hican,	etc.)		Black, Whit	e, etc. ite	
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B0)	requires that the death certific been signed by the attending should be detached for use as	Physician/M	in the past 12 m 1 ☐ Yes 2 🛭 9 ☐ Unknown	nonths? No	1	4 Pregnant a 9 Unknown			Other (specify)	~,				Month	Day	Year
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0 0	nding tth. : After e fune	cate	1 X Natural 2 Accident	5 Pendi	ing igation	(Month, Da		injury	worl			escribe no	w injury	y occurred	LLVII	6
Division of Vital Records, P.O.	r Atter er dea rector by the	Certificate:	3 Suicide 4 Homicide	6 Could	not be	28e. Place of Injubulding, et			eet, factory, office			cation (Str		d Number or Ru	ral Route Nu	nber,
2	oital or urs aft ral Dii			· W												
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 (Check 2 only one) 3		Examine	cian: To the best of er: On the basis of e Practioner: To the	xamination	and/or inves	igation, in my opini	on, death occu	urred at the tim	e, date and	d place,	, and due to the	cause(s) and r	nanner stated
	To the within To the Comp		29b. Signature and ti	itle of certific	r /	M		. l	29c. Licens		ina piaco, ana c			te signed (Mont		
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	121		30. Name and address Suresh M.	Ss of person	who co	mpleted cause of d	eath (Item	23a) (Type, F	Print) Avenue	Havre	de Gr	ace,	Mar	yland 2	21078	
	Sta	te	31. Date filed (Month	, Day, Year)	Y	32. Rejetr	ar's Signat	ure						-		
	Registra	ar		NAY 2	9 20	12	4	1. 1	ald							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Physician/ 23, 2012 7:44 Jean Ζ. Smith A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 9726 Duffer Way Montgomery Montgomery Village 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 1 🗆 M 2 😿 F March 16, 1946 Pennsylvania Director 185-36-2647 66 Usual Residence of Decedent 28a-f show 10b. County 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 🗌 No Maryland Maryland Montgomery Montgomery Village 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9726 Duffer Way 20886 United States 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. o. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: "natural", White 3 Widowed 4 X Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) S.B.A. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with.
Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic enter. Federal Government Deputy Director Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Vincent Znaniecki Julia Kocikowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18753 Diller Drive, Hagerstown, Maryland 21742 Samantha A. Davis /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State May Montgomery Crematorium, Ind Bethesda, Maryland 4 Donation 5 Other (Specify) 2012 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 rettebro 23a. Part 1. Other the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Years Physician/ disease or condition resulting in death) Metastatic Ovarian Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has have sinned by the Attending Control of the Funeral Director. Cause (Disease or iinjury that initiated events burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 as IE EEMALE use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery Box (for in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Dav Year 9 Unknown s been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) completed filled in by the funeral 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pendina Division s after death. 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatų 29c. License numbe 29d. Date signed (Month, Day, Year) 67258 May 25, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicholas J. Ferrell, MD 9707 Medical Center Drive, Ste. 300, Rockville, MD 20850 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

MAY 2 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death May 25, Physician/ 2:23 PM 2012 Mildred Sporer J. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Lutherville Stella Maris Hospice Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min (Month, Day, Year) 06/18/1919 92 Director 218 10 7632 1 □ M 2 🕅 F Maryland 27 is merked other then "naturel", or Items 23e or 28e-f ebov traumetic event, the Medical Exerciter must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 XNo Maryland Baltimore Middle River 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21220 United States Apt.320 705 Compass Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Time Clock Mfg. Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file n end Mentel H Is merked o ဥ Myrtle Dasch John Wesley Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pege 1 end 2 sh Department of Heelth er Importent: If Item 27 is eny Injury or other trau once. Louise S. Brickey (stepdaughter) 8 Box Circle Essex Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Bayview Crematory Inc: 5/27/2012 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Finneral Service Licens 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immedia Cruse (Final disease of notition resulting in death)

PNEUMONIA

Due to (or as a consequence of the consequ Interval Between Onset and Death Physician Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) signed by the attending physicien and d be deteched for use es the burlei-transit Exam Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy SPORER in the past 12 months?
1 Yes 2 X No Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MILDRED 1 Yes 2 No 3 Probably Unknown Completed this certificate hes been si el director, pege 2 should 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 X No prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Hospitel or Attending Physicien:
 24 hours efter death.
 Funeral Director: After this certifical etely filled in by the funeral director, 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 🗷 Other (Specify) HOSPICE 1 ☐ Yes 2 👿 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 X Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending Division 1 Yes 2 No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hoep within 24 hou To the Funel completely fl 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certify 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 TRACIE L. MORGAN, CRNP 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

MAY 29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 220-06-9269 09/13/1980 Director 1 □ M 2 🛛 F Maryland 31 28a-f show 10d. Inside City Limits 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at the Maryland Director Baltimore Maryland XXYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral with 21226 1627 Locust Street U.S.A. be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian . Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. Yes 2 No Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev any injury or other traumatic ev once. ည Tammy Busch Michael Filicko 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1627 Locust Street, Baltimore, Maryland 21226 Scott Scheuerman (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 05/30/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Similare of Funer 1 Succession 150 Name and Address of Facility
Bruzdziński Funeral Home, P.A.
407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Expertine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ DEFSIS Medical realting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) executed Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 perform this certificate 1 ☐ Yes 2 ☐ No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 X No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? _1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After injury Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 29b Signature and title of cert 29d. Date signed (Month, Day, Year) 29c. License number S-00C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) But more MO HRISTOPPICE 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ hard Sennett 2012 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Mercy Medical (enter ltimore If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 38 220 6998 10/26/1942 Maryland **Director** 1 **X**M 2 □ F 69 Yrs iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland | Baltimore 1 Yes 2 XNo Essex 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21221 Beechwood Avenue 1711 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 If Yes, Give Year or Dates Maryland 21215-0036 1 Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; any injury or other traumatic event, the Medical Exar Specify: white 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Funeral Home Mortician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anna Estelle Mulligan Richard Samuel Sennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brigid Sennett (wife) 1711 Beechwood Avenue Essex Maryland 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 5/29/2012 Baltimore Maryland Oaklawn Cemetery Donation 5 - Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA Service Lic 1407 Old Eastern Avenue Essex Maryland 21221 Enter the disease, or co or heart failure. List on mplications the aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rone cause on each line. Interval Between Onset and Death ause (Final Immediate Physician Hochic disease or condition Months Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed and I-tran Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown the detached g Unknown P.O. I signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2 🗌 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ✓ Inpatient 2 □ ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in East. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending Natural Natural work' Certifica 1 🗌 Yes 2 🗌 No filled in by the 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifie

Himore, MD

21202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:410 DOROTHY CECILIA HARRIS SCHMICK Wai Medical 4b. City, Town, or Location of Death Baltimone 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Agnes N/AIf Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Country) 215-12-8619 Director 1 🗆 M 2 🛛 F 89 Aug 8, 1922 Unknown Usual Residence of Decede 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ **Funeral Director** Examiner must be notified 1 X Yes 2 No Maryland N/A Baltimore City 10e. Street and Number 10g. Citizen of What Country? 5711 Plainfield Avenue 21206 USA items ; Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by "natural", or permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify. White 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harris Emma Lillian Forest (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Lynne Schmick 5711 Plainfield Avenue, Baltimore, MD 21206 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dul. Valley Mem Grdns 5/30/2012 Timonium, Maryland Donation 5 Other (Specify) 21. Signat of Injuly Sérva Lideré Martin D. Lawson MITCHECL-WIEDEFELD FUNERAL HOME, INC 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician disease or condition resulting in death) cano week Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? STEMI, CHF, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 **N**O 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28h. Time of 28c. Injury at work? 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) MD PGYI

State Registrar

lov

Ave., Baltimore,

completed cause of death (Item 23a) (Type, Print)

amend 5,per fh,g927 5-29-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 = For State Registrar	State of Maryland / [Department of Health and Certificate of Death				
Physician/	1. Decedent's Name (First, Middle	_1 /	oormoute of Boam	2. Date of Death	Day Year 3. Time of Death		
Medical Examiner	Anthony 4a. Facility Name (if not institution,	Stewart give street and number)	4b. City, Town, or Location of De	Month MAY eath	27, 2012 10,05 4 M 4c. County of Death		
	GENESIS	CATEN MANIR		IMERE	N/A		
Funeral Director	5. Social Security Number 171 4-56-8171 Usual Residence of Decedent	6. Sex 7. Age (In yrs. last birti	nday) If Under 1 Year If Under 24 H Months Days Hours Mi Yrs.				
yland f show ed at	100	10c. City, Town	1	110/100,000,	10d. Inside City Limits		
death with the Maryland riems 23a or 28a-f sho ner must be notified at Euneral Director	MARYland Dine Street and Number	Altimore Wind	SOR MILLS	10g	1 ★ Yes 2 □ No		
death with the rems 23a con must be	3550 Derby S		21244		USA		
after dea after dea xaminer	1 Never Married 2 Marri	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ► No If Yes, Give	 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put 1 ☐ Yes 2	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.		
21215-0036 within 72 hours after tene. Than "natural", of the Medical Exam Completed by	3 Widowed 4 Divorced 15. Deceden (Specify only highes	Year or Dates. 's Education 16a.	Decedent's Usual Occupation	16	Specify can Americans b. Kind of Business/Industry		
d 21215 ed within 72 Hygiene. Therefran " ant, the Mec		College (1-4 or 5+)	(Give kind of work done during most of w life. DO NOT use retired) ZANE OPECA-FOR	/orking	Bethlehem Steel		
			18 Mother's N	Name (First, Middle, Maid	den Sumarne)		
Maryland 2 should be filled th and Mental Hy 27 is marked oth traumatic event	19a. Informant's Name/Relationsh	p (Type, Print) 19b.		1 - 1 11	y or Town, State, Zip Code)		
Baltimore, Me permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau	20a. Method of Disposition	20b. Place of	Disposition (Name of		itsor Mills Md 21244 c. Location - City or Town, State		
altimore, mit. Page 1 and partment of Hee portant: If item y injury or othe	1 Burial 2 Cremation 4 Donation 5 Other (S)	pecify) MEA	Corematory or other place)	e02,2017 B	AHIMORE MARYLAND		
Balt permit. Departr Importa any inji	21. Signature of Funeral Service Li	1. Ceselare	22 Name and Address of Facility Alamond Market M. WAL	lace fune St. Ball	o Md 21229		
Physician/	23a. Part H. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final		ot enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death		
Physician/ Medical Examiner	disease or condition resulting in death)	Due to (or as a consequence of	CREATIC CAN	LER	EEW MS THY		
J. J	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence o	7):				
60 ate be executed hysician and the burial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	າ:				
- 2 m 6 -		d					
687 certifica certifica use as t	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery		
S-TEWART Ision of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate be ar death. The strong of the serificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the burtificate: To Be Completed by Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	Ectopic pregnancy Other (specify)		Month Day Year		
P.O. P.O. s. that the se that the be detailed by P.P.	Part II. Other significant condition	s contributing to death but not resulting in	the underlying cause given in Part I.		co use contribute to the cause of death?		
ords require been si should	7314 12311	/ / /		1 Yes	2 No 3 Probably 4 Unknown		
Vital Records, system The law requires its certificate has been significate to page 2 should it.				- autopsy performed 1 ☐ Yes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 \(\text{Yes} \) 2 \(\text{D} \) No		
Vital hysician: nis certific	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	26. Place of Death (Chaptient 3 DOA Other: 4 Nursing		a 6 Other (Specify)		
n of ding Ph h. After th funeral	27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	28a. Date of injury 28b. Ti		4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred			
Division of Vital Records, all or Attending Physician: The law requires s after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be a look to be the funeral director, page 2 should be a look to be the funeral director.	2 Accident Investigation 3 Suicide 6 Could not determine	ot be		28f. Location (Street City or Town, St	t and Number or Rural Route Number, ate)		
Division of V To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral d Medical Certificate: Tc	29a. Certifier 1 Certifying	Physician: To the best of my knowledge, d	eath occurred at the time, date and place	e, and due to the cause(s) and manner as stated.		
o the H vithin 24 o the Fi	(Check 2 ☐ Medical Exonly one) 3 ☐ Certifying I	aminer: On the basis of examination and/or durse Practitioner: To the best of my know	investigation, in my opinion, death occurre ledge, death occurred at the time, date and 29c. License number	place, and due to the ca	ace, and due to the cause(s) and manner stated. use(s) and manner as stated. Date signed (Month, Day, Year)		
		mo	Do: 62/2.		MAY 27 2.12		
2	30. Name and address of person w	no completed cause of death (Item 23a) (T	/pe, Print)	GERD C	CLUMBIA MO 21644		
State Registrar	31. Dath fill de Martin 9 2012	Au 32. Regist I 's Sigr		- +	CLUMBIA MD 21644		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 14:00 P.M JOHN J. STALLINGS 05/22 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN BALTIMORE MOSPITAL MD Security Number | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 19, 1929 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F **Director** Yrs Maryland 216-24-8394 82 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f shor ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Md. Balto. Nottingham 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4 Brigantine Court 21236 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces'
1 X Yes 2 If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 2 \ No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced 1952-1956 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 <u>Electrical Distribution</u> BG & E Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Emil G. Stallings Clotilda H. Whitthauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J. Stallings spouse 4 Brigantine Court Nottingham, md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or of 1 Durial 2 😾 Cremation 3 Demoval from State 4 ☐ Donation 5 ☐ Other (Specify) 5-25-2012 Glen Burnie, Md. Atlantic Crematory Signature of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Home, Inc. Nauwah 9705 Belair Road Nottingham, md. 21236 23a. Part the first the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STAGE disease or condition END COPD (HYPOXIA MONTHS/W Medical resulting in death) Due to (or as a consequence of): **Examiner** MONTHS/YR-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Year 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performe certificate 1 🗆 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ Inpatient 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral di 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 05 $M \cdot D$ 22/2012 RES 000 9x1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SRITIKA THAPA 5601 LOCH RAVEN BLVD. BALTO.MD.21239 32. Registrar's Signatur State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# SperFH, G930,8//2012, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7.06 PM Phyllis Month M. Shimonkevitz Medical 20 4a. Facility Name (if not institution, give street and number) **Examiner** or Location of Death 4c. County of Death 100 netal Hmo Funeral Security 4373 6. Sex Age (In yrs. last birthday, If Unde 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth Months Days Min (Month, Day, Year) Director 1 🗆 M 2 🔀 F 80 Yrs July 4, 1931 Iowa sidence of Decedent 28a-f show 10a, State 10b. County with the Maryland be notified at 10c. City. Town or Location **Funeral Director** 10d. Inside City Limits 1 Yes 2 X No MD Baltimore Pikesville 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 4001 Old Court Road Apt 207 21208 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14 Race - American Indian Armed Forces "natural", or ģ 1 Never Married 2 Married Black, White, etc. Yes 2 No and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🛣 No Specify: Completed 3 X Widowed 4 Divorced White er than "natura the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker marked other Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o ဂ္ Samuel E. Patterson Ethe1 McConnville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Sheryl Shimonkevitz Department of Health Important: If item 27 any injury or other the Daughter Sunbrook Road Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cem. 5/30/12 Pikesville, MD Signature of Funeral Bervice Licensee 22. Name and Address of Facility 11824 Reisterstown Road ten 6 ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner umonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury signed by the attending physician and d be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown him on kevitz been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 1 Yes Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1X Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie (Check only one) 29b. Signature and title of certifier 1ay 26 Name and address of person who completed ca nva 31. Date filed (Month, Day, Year) State 2 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Manuel Ernest Sanchez State of Maryland / Department of Health and Mental Hygiene 2012 16730 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) Physician/ Date of Death Month Day May 7, 2012 **Medical Examiner** Manuel Ernest Sanchez 0932 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 21262 Winding Way Lexington Park St. Mary's 5. Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director Months Davs Hours Min unk 1 M 2 F 72 Country) CA 03/01/1940 Usual Residence of Decedent 10b, County 10a State 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. MD 1 Yes 2 No St. Mary's Lexington Park death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21262 Winding Way 20653 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, i. Pages 1 and 2 should be filed within 72 hours after death witment of Health and Mental Hygiene, retart; If item 27 is marked other than "natural", or items or other transmatic event, the Medical Examiner must be. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White etc. Yes 2 X No 3 Widowed 4 Divorced 1⊠ Yes 2 No specify: Latino If Yes, Give Year Specify: Latino 2 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore, MD 21215-0036** Social Services Aid Community Worker 9yrs 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Ernest Manuel Sanchez Aurelia DeAnda Garcia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Arrietta Sister 2116 East RedWood <u>Drive Glendon CA 91741</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Atlantic Crem 05/23/12 4 Donation 5 Other Specify: Glen Burnie MD 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover 1oms Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and Medical Death a Codeine Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed d. Physician/Medical AMENDED 23a, 27, 28a-f, per me, g927 5-30-12 sm the attending physician and for use as the burial -X UNPENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery dent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 [Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been ector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 1 🗸 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical Division of Vital 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 5 Residence 6 🗹 Other Scene After this 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Natural death. Director: d in by the fi 5 Pending 1 Yes 2 X No unknown fd 5-7-12 fd 9:30 am 2 Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 21262 Winding Way Lexington Park, MD. hours after 3 Suicide 6 X Could not be determined (Specify) Residence the Funeral 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME O.C.M.E. May 8, 2012 e and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Day 05 2012 Year 20 Betty L. Shoemaker 3:45 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7978 Nolpark Court Apt. 102 Glen Burnie Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Min (Month, Day, Year) **Director** 213-32-7154 1 □ M 2🛣 F 76 08/04/1935 MD 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Anne Arundel Glen Burnie 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? items 23a Nolpark Court 7978 Apt. 102 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 'natural", or þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 K Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Nursing Assistant Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Roy D. Crostic Alice May Earehart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Mrs. Laurie Sims / daughter 5007 Clover Mist Drive, Apollo Beach, FL 33572 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 0 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 05/23/2012 Crownsville, Maryland MD Veterans Cemetery 22. Name and Address of Facility 1 21. Signature of Funeral Service License 2nd Ave, SW Glen Burnie, MD M01357 Singleton Funeral & Cremation Services, P.A. Part 1. Softer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ emma QC disease or condition 1)4000 Medical resulting in death) Due to (or as a consequence of) 0 **Examiner** 1001 Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician; The law requires that the death certificate be executed 1510 that initiated events r as consequence of resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 V Month Pregnant at time of death Day Year Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2 **X**Vo Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month. Dav. Year

Registrar DHMH 17 Rev 06-2011

State

325

HOSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MAY **GERALD** 2012 STEIN 05:00AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth Hours (Month, Day, Year) Director 212-36-3744 1 X M 2 □ F 73 02/02/1939 MD parmit. Paga 1 and 2 should ba filad within 72 hours aftar death with tha Maryland Department of Haatilt and Mantal Hyglana. Important: If team 27 is marked other than "natural", or itsms 23a or 28a-f show any injury or other traumatic event, the Maddael Eventher must be notified at 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits Director 1 Yes 2 No BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9243 COUNTESS DRIVE 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No If Yes, Give Specify 3 Widowed 4 Divorced Specify: Completed Year or Dates WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SALES PRINTER / COMPUTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 PAUL STEIN MINNIE YANKELLOW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN STEIN / WIFE 9243 COUNTESS DRIVE, OWINGS MILLS. MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State HEBREW YOUNG MENS 4 ☐ Donation 5 ☐ Other (Specify) 05/24/2012 WOODLAWN, MD 21. Signature of Juneral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) wanaw Medical onsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examl burlal-transi The law requires that the death cartificate be executed Cause (Discase or injury that initiated events resulting in death) Last Due to (or as a consequence of): attanding physician for usa as tha burk Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day ad by tha a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signad d ba da 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an paga 2 (autopsy cartificata 1 ☐ Yes 2 ☐ No or Attanding Physician: æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Aftar this funara 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending To the Hoapital or Attandin within 24 hours after daath.
To the Funsral Director: Aft complataly filled in by the fu work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature ar 20071287 ess of person who completed cause of death (Item 23a) (Type, Print) * 4105, Baltimene, MD 0

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Helen Physician/ 2012 22:04 Medical ot institution, give street and nu Examiner 4c. County of Death 9. Birthplace (State or Foreign **Funeral** (Month, Dav. Year) Countr 63 **Director** 1 M 2 1 an 28a-f show at 10b. County 10c. City, Town or Location 10d. Inside Director City Limits must be notified ramand 1 Yes 2 No or 10f. Zip Code 10g. Citizen of What Co Funeral items 23a Wilkers 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubage Mexican, Puerto Rican, etc.) 11. Marital Status Examiner 14. Race - American Indian, Black, White, etc 0 þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Black "natural", Specify Completed 3 Widowed 4 Divorced Year or Dates marked other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Care Be 18. Mother's Name (First, Middle, Majden Surname) and Mental I is marked o ဂ္ Kobinson Darder Just 1 and 2 shr Juportant of Health and Important: If item 27 is many injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 268-Ave daughter Wilkens 20a. Method of Disposition 20b. Place of Disposition (Name of Date Town State 📭 Burial 2 🗌 Cremation 3 🗌 Removal from State Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Jevice Licensee HIMOR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, If any, each of to minimize cause. Enter Underlying Cause (Disease or injury Examin Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): burial Physician/Medical Records, P.O. Box 68760 the hha as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) for in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? perform Yes 2 1 🗌 Yes Be Division of Vital the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner?
1 Yes 2 2
27. Minner of Death Hospital 2 🗆 No Other: 유 1 Inpatient 2 R/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th Certificate: 28b Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 Yes 2 No 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) 0066588 2012 30. Name and who completed cause of death (Item 23a) (Type, Print) Are Baltimore 900 Caton State Registrar HMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 05: 45 AM JAMES WILLIAMS 21 12 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A MedStar Good Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5 (Month, Day, Year) 5 / 3 1 / 1 9 3 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 🔀 M 2 🗆 F 80 246-40-6384 NC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Execute in an inust be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD N/A Baltimore 1 DXes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 908 Argonne Drive 21218 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🛣 No Specify: ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 5th College (1-4or 5+) Steel Worker Steel Company N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William A. Williams Beulah Ruffin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Olivia Lewis-Daughter 911 Argonne Dr. Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/26/2012 Laurel, MD National Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H-East 1101 21. Signature of Funeral Service Licensee North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Devere Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sensis Sequentially list conditions, Due to for as a nonsectioned off. Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Pulmonary E

Due to (or as a consequence of): edemo attending physician and for use as the burial-trar Physician/Medical mbarchion ST myucardial clevation IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. the 1 □Yes 2 □No 9 Unknown ģ Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Anthritis 1 Yes 2 No 3 Probably 4 Unknown Completed metho fre xate 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? this certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2. No of Vital To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) Director: After the in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

MD

MD

WIN

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES 000

5601 Loch Raven Boulevard, Baltimore, MD21239

05, 21, 12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ruth B. West May 23 Physician/ 2012 2:14 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Springwell Home Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Country) 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2XX F 92 Jan 7, 1920 578-32-3825 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21209 U.S.A. 2211 West Rogers Avenue 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2XXNo Specify. White Specify: "natural" Completed 3 XXVidowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene.
77 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Secretary U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rudolph John Becker Hermine Meyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a Roberta Proctor (Daughter) 5734 Pimlico Road Balto, MD 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XX cremation 3 Removal from State 4 Donation 5 D Other (Specify) injury or Department of Important: If any injury or Atlantic Crematory 5/25/12 Glen Burnie, MD 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21. Signatur of Funeral Service Licenses 3631 Falls Road Balto, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final SANWARY 2017 Physician/ disease or condition Medical resulting in death) **Examiner** MAY 17 2012 UMON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of Exami and Due to (or as a consequence of) resulting in death) Last bunalattending physician for use as the buna Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death the 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RIGHT LUNG MASS Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? this certificate 1 🗌 Yes 2 No Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 **2** No Other: 4 Nursing Home 5 Residence 6 Other (Specify) SSISTED LIVIN မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ithin 24 hours after death. b the Funeral Director: Aformpleted filled in by the fu ☐ Accident 1 Tyes 2 🗌 No Investigation
6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

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29b. Signature ar

26209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 16b, 19a, per fh, g927 5-29-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 3:59 AM Medical 4b. City, Town, or Location of Death **Examiner** Limore 10WSON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 F **Director** Yrs. or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Machael Examinar must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗷 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21201 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status If Yes, specify Cuban Black, White, etc. fces? 2 ☐ No 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Blac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) afmine Farming arma UNKNOWN Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည ames a/ 19a. Informant's Name/Relationship (Type, P 19b. Mailing Address (Street and Number or Rural Route Nymber, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Services 21. Signature of Funeral Service License Address of Facility MD 21103 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician Ischemic rone Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): igned by the attending physician and be detached for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month 5 Other (specify) Pregnant at time of death 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by discese novaserlas 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been si completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Hospital or Attending Physician: The 24 hours after death.
 Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending work? 1 ☐ Yes 2 🗌 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifie 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 25, Day 2012 7:32 Weinel Gustav George Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring Montgomery 13103 Jingle Lane Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Months Hours October 27 IIIInois Director 93 1918 335-01-0970 Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13103 Jingle Lane 20906 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No 1944-Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1946 1 ☐ Yes 2 🛛 No Specify: "natural", If Yes, Give Year or Dates. Specify: 3 X Widowed 4 □ Divorced Completed White other traumatic event, the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12 Federal Government Supervisor marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Blaum Gustav Weinel and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health item 27 2640 Cameron Way, Frederick, Maryland 21701 Sandra W. Clements/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott Page 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parklawn Memorial Park May 30, 2012 | Rockville, Maryland Signature of Funeral Service Licensee Robert A. Fumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850–2805 2 Phr M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician Cardiomyopathy Years disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician a the burial-Medical that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Year Pregnant at time of death the g Unknown Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Sick Sinus Syndrome, Pacemaker To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has page 2 autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After (Month, Day, Year) 1 X Natural 5 Pending within 24 hours after deaun.

To the Funeral Director: Aff 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi Unio D0025080 May 25, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gravino, M.D. 10313 Georgia Avenue #307, Silver Spring, Maryland 20902

DHMH 17 Rev 7/2009

State Registrar Frank N. Grav
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Maryland / Dep	eartment of Health and I	Mental Hygien Reg. N	2012 16738			
Physic		1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death Year 3. 2012 544 A M			
/Med Exami		4a. Facility Name (If not institution, give s	•	4b. City, Town, or Location of Death	11 1	c. County of Death			
	Į	Johns Hopkins Bayviev		Baltimore If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign			
Funeral Director		5. Social Security Number 6. Sex 1 Usual Residence of Decedent	M 2 F 7. Age (In yrs. last birthday)	Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	1937 MARYLAND			
the Maryland 28a-f show otified at	ctor	10a. State 10b. County	10c. City, Town or L. Baltine			10d. Inside City ⊔mits 1 Me Yes 2 □ No			
th with the 23a or 28 st be not	Funeral Director	10e. Street and Number	b WAY	10f. Zip-Code 212 05	10g. C	Citizen of What Country?			
and ZIZIS-UUSO be filed within 72 hours after death with the Maryland hal Hyglene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	pecify Yes or No- b Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Whate			
K I 3-UC hin 72 hou a. "natural Medical Ex	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16a. Dece	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	king	Kind of Business/Industry			
led wit lygiene ygiene ner tha	S	17. Father's Name (First, Middle, Last)	NA FAC	Tony Worker	me (First, Middle, Maid	hoe factory			
and had had had had had had had had had ha	To Be	FRANK	Heili	MAN ANGE	10	Unkronn			
Maryi nd 2 should ith and Me 27 is mark		19a. Informant's Name/Relationship (Type	Husbard) 1115	ling Address (Street and Number or Re 7 New comb W	'Ay Baltin	WILL MARY LANG			
es 1 ar of Hea of Hea of Hea		20a. Method of Disposition 1 Dourial 2 Cremation 3 R	20b. Place of Disp	position (Name of ematory or other place)	Date 20c.	Location - City or Town, State			
Daltimor bermit, Pages Department of mportant: If II iny Injury or once.		4 ☐ Donation 5 ☐ Other (Specify)	Holy Rede	eener Centry	16 2012 13V	Itinore, MARYLAND			
Depariment of the poor once.		21. Signature of Funeral Service 11558	La company	22. Name and Address of Ficility	"hOTNACK,	MORE, MARIJANDAUX			
Physician		23a. Part 1 Enter the disease, or complishook, or heart failure. List only on Immediate Cause (Final	cation, that caused the death. Do not en	nter the mode of dying, such as cardia		Ap oximate Interval Between Onset and Death			
/Medical Examiner	ı	disease or condition resulting in death)	Due to (or as a consequence of):	251					
LXammer	je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):						
cuted od ransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	use. Enter Underlying use (Disease or injury t initiated events c						
rou, te be executed tysician and he burial-transit	dical E	resulting in death) Last	Due to (or as a consequence of):						
a s e	Medi	IF FEMALE:							
e death cer he attendin hed for use	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year			
w requires that the been signed by the	by Ph	Part II. Other significant conditions con	stributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?			
cords, v requires t been signe should be	ted b	High cholesto	1 🗌 Yes	2 No 3 Probably 4 Unknown					
rutal necor	Completed				24a. Was an autopsy performed?				
VITALISTE ILICIAN: IL	Be	25. Was case referred to medical examiner?	lospital:	Other:	th (Check only one)	C Other (Coopie)			
	ը 2	27. Manner of Death	28a. Date of Injury 28b. Time	of 28c. Injury at	ome 5 Residence 28d. Describe how in				
Attending Physician: Attending Physician: or death. ext after this certific by the funeral director,	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year) Injury	M 1 Yes 2 No					
by ect of	Certification:	4 Homicide determined	28e. Place of injury - At home, farm, so building, etc. (Specify)		ctory, office 28f. Location (Street and Number or Rural Re City or Town, State)				
Hospital or 24 hours afte Funeral Dir letely filled in	edical		vician: To the best of my knowledge, dea ner: On the basis of examination and/or i and manner stated.						
To the within To the compl	Me	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month, Day, Year)			
		1	— MD	D0069427	1 140	y 23, 2012			
		30. Name and address of person who co	AMM, D		Eastern Aven	ue, Baltimore, MD, 21224			
S Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's signatur						

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day tustin 9:35 20/2 Medical e (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Pinewood Raldimore Himore Birthplace (State or Foreign Country) cial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day **Funeral** 1 🗆 M 2 💢 F Months Hours Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 Yes : Baltímore, Marýland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) North Carolina econday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ of Health and Nitem 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informa Name/Relationship (Type, Print) Smi Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Baltimore, MD 3/120/2 Zion 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensel H-East 1101 E. North Name and Address of Facility March timore 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or s consequence of): cancer months disease or condition resulting in death) Medical Due to (or Examiner Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) Cause (Disease or linjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ g ☐ Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? the Hospital or Attending Physician: The law requires dementia obstruction, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No diabetes 24a. Was an autopsy performed this certificate has Yes 2 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 Natural iniurv 5 Pending 2 Accident
3 Sulcide
4 Homicide Investigation within 24 hours after deat To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Vertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 32. Regis

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12 36 PM ANDERSON THOMAS CARYLE MAY 2012 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Medical Center Baltimore 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) **Funeral** 09/27/1953 58 MD 215-62-729 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. MD Baltimore 1 X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code USA 21224 3529 E Baltimore Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 X Yes 2 □ No
If Yes, Give Black White etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Š 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3529 E Baltimore St Baltimore MD 21224 19a. Informant's Name/Relationship (Type. Print) Sara Anderson Sanchez wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crem 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5/18/12 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC **Physician** ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of, or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à DIABETES 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ALCOHOL autopsy performed?

1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Hospital: 1 ≰Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To nours after death.

neral Director: After this of filled in by the funeral di 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation Injury 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a To the Funeral D 🕵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier NIRMAL KUMAR RES-000 MAY 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIRMAI KUMAR 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 28 9:30 A M 2012 Marquerite Giraud Anderson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Chevy Chase Montgomery 5303 Kenwood Avenue 8. Date of Birth (Month, Day, Year) ial Security Number If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Director 556-26-6630 1 🗆 M 2 🔀 F June 18, 1918 93 Canada show 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f Chevy Chase 1 Yes 2 X No MD Montgomery ō 10e. Street and Number 10g. Citizen of What Country? 23a United States 5303 Kenwood Avenue 20815 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than " Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and ...
of Health at...
* item 27 is mat...
* traumatic ev မ Elizabeth Irene Chambers George Giraud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 575 Commonwealth Place Sarasota, FL 34242 Marilyn Boyle / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o once. ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 5/30/2012 Woodbine, Maryland 21. Signature of Funeral Service Licer Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Disseminated Malignant Neoplasm disease or condition Medical resulting in death) **Examiner** Malignant Neoplasm of Liver Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): burial-tran Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 2 XNo Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Chronic Airway Obstruction this certificate has been signal director, page 2 should? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 X No death? Division of Vital funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 1 🗆 Yes 2 🗶 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af

State

29a. Certifier

29b. Signature and title of certifier

Registrar DHMH 17 Rev 06-2011 person who completed cause of death (Item 23a) (Type, Print)

Geoffrey Coleman, 1355 Piccard Dr. Rockville, MD 20850

29c. License number

D37142

29d. Date signed (Month. Day, Year)

May 29, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 24, 2012 Ronald Bruce Allen 12:45 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist @ GBMC Towson Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Min. Hours 218-26-3694 Director 1**₹** M 2 □ F 81 Mar. 14, 1931 Maryland Usual Residence of Decedent ge 1 end 2 should be filed within 72 hours efter death with the Meryland it of Health and Mentel Hyglene. It flem 27 is marked other then "netural", or Items 23e or 28a-f show or other traumetic event, the Madical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Directo 1 Yes 2 No Baltimore Glen Arm Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 11630 Glen Arm Road G24 21057 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed 3 Divorced 4 Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Public Schools Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (Unknown) (Unknown) (Unknown) Luther Emory Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6900 Avondale Road, Baltimore, Maryland 21212 Sarah Loeffler / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pege 1 e Depertment of H Important: If ite eny Injury or ot 1 DBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/26/2012 Bel Air, Maryland Zion UMC Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Fretun disease or condition resulting in death) Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin ettending physicien end for use es the burlei-trensit cincing The lew requires that the deeth certificate be executed Cause (Disease or injury that initiated event Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (spegify) in the past 12 months? Day signed by the eid d be deteched f ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of r this certificate hes by erel director, page 2 sl 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes To the Hoapital or Attending Physicien: I within 24 hours efter deeth.

To the Funeral Diractor: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 □ No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence & Other (Specify) NU Si Lip 27. anner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔲 Natural 5 🔲 Pending injury 1 ☐ Yes 2 ¥ No TRIPped on chair 2 Accident 3 Suicide MAY 21, 2012 Investigation 0400 AM 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide 11630 GjentrmRa, Clanton M) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and the time, date and place, and the time date and place. 29a. Certifier (Check only one and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) X 24 20 R 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charces CHANCES MM 670LN_ 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2012 Registrar

12-03820		r Print in Black Ir					gible.	
Paul Henry Anders	on, Jr State	of Maryland / Depa			Mental Hy	giene	20	112 1671
	Registrar		rtificate of	Death		Ro 2. Date of Dea	eg. No. 20	3. Time of Death
Physician Medical Examine	Baul U Andor	son Jr.				Month May 19, 2	Day Year	0819 hrs
and a	4a. Facility Name (if not institution, giv	e street and number)	4	b. City, Town, or Lo	ocation of Death		4c. County of	Death
	1211 E. Federal Street			Baltimore			N/A	
Funeral	5. Social Security Number 6. Se	7. Age (In yrs. I	ast birthday)					Birthplace (State or Foreign
Director	220-02-4420	M 2□F 41	Yrs.	Months Days	Hours Min.	03/1	1/1971	Country) MD
A	Usual Residence of Decedent 10a. State 10b. County	Inc. City	Town or Location	n				10d. Inside City Limit:
ow any	MD	I/A	TOWN OF EGGGR	m Baltin	nore			1 X Yes 2 N
e Maryland or 28a-f show fied at once.	10e. Street and Number	/A		10f. Zip Code		1	0g. Citizen of Wha	it Country?
the Maryland to 28a-f sh	1211 E. Federa	l Street		21202	2		U.S	.A.
with the same of t		12. Was Decedent Ever in U		Decedent of Hispa	nic Origin? (Spe			American Indian, Black,
r death with or items 23 must be no	1 Never Married 2 Married	Armed Forces?	If Ye	s, specify Cuban, N	Mexican, Puerto R	ican, etc.)	White,	
ral", o	3 Widowed 4 Divorced	or Dates:		Yes 2 🔀 No :			Specify:	Black
72 hours na "natur sal Exam	15. Decedent's Education (Specify or Elementary/Secondary (0-12)			's Usual Occupatior st of working life. D			Univer	ses/logustryof
36 sin 72 sin 72 dical	12th Grade	College (1-4 or 5+)	S	ecurity	Guard		MD Hos	pital
5-0036 ied within ' tygiene. other that			·	18.			Maiden Surname)	
21215-0036 suld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Paul H. Anders	son Sr.		1000 m 170mm 1000 1000	Vivian	Joh	nson	
hould Me is man	19a. Informant's Name/Relationship (T			Address (Street a				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shouliury or other traumatic event, the Medical Examiner must be notified at once. To Re Commissed by Euroaral Director	Vivian Anders			ion (Name of ceme		Date		, MD21205
Baltimore, bernit. Pages I ar Department of Hee Important: If ite	1 Burial 2 Cremation 3	Romoval from State	crematory or oth			3-12	1	ore, MD
timent ritent:	4 Donation 5 Other Specify: 21. Signature of Funeral Service Dipen						1	
Balt permit. Departs Import	21. Signature of Funeral Service Licen		21	40 N. Fi	Jerown Liton A	Jr. F	uneraı Baltimo	Home PA re, MD 2121
Physician	23a. Part I. Enter the disease, or comp							t Approximate Interva
, IMedical	failure. List only one cause on ea Immediate Cause (Final disease a.	^{ch line.} Cardiac Arrhyt	hmi o					Between Onset and Death
Examiner		Due to (or as a consequence of						
_	Sequentially list conditions,	Myocardial Fill Due to (or as a consequence or						
900	if any, leading to immediate cause. Enter Underlying Cause C.	pue to (or as a consequence o	1).					28
tecuted and - transit	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	f):					
		AMENDED 22 - 1- 27	7	-020 (1	15 10			
ox 68760, anth certificate be en attending physician or use as the burial stician/Medic	IF FEMALE:	AMENDED 23a-b, 27		•8928 6−1	15-12 sm		23d. Date of d	elivery
1876 rtificat ing ph	23b. Was decedent pregnant in the past 12 months?	1 Live birth		al death 3	Ectopic pregnanc	су	Month	Day Year
Box 68760, e death certificate be the attending physic of for use as the burnvelcian/Med	1 Yes 2 No 9 Unknown	4 Pregnant at time of de	ath 5 Oth	5 Other (Specify)				
O.O. Box 68760, that the death certificate be e ned by the attending physician detached for use as the burial by Physician/Medii	Part II. Other significant conditions	9 Unknown	esulting in the ur	derlying cause give	en in Part I	23e. Did to	bacco use contrib	ute to the cause of death?
ires that signed by the detail		ooning to dod to but not to	Journal of the same	,,		1 Yes	2 No 3	Probably 4 🗸 Unknown
Records, P.C. The law requires that ficate has been signed by page 2 should be detered by Completed by						24a. Was		ere autopsy findings available
COT law r has b e 2 sh							rm <u>ed</u> ? de	or to completion of cause of ath?
Registrate True	25. Was case referred to medical			26 Place of	Death (Check on	1 Yes	2 No 1	Yes 2 No
Vital Records, bysician: The law requir this certificate has been to director, page 2 should a Completer.	examiner?	lospital: 1 Inpatient 2	ER/Outpatient				Residence 6	Other: Scene
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. *I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by P	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time of In				how injury occurred	
OD sath.	1 X Natural 5 Pending 2 Accident Investigation			1 Yes	2 No			
Visi	2 Accident Investigation 3 Suicide 6 Could not	28e Place of Injury - At hi	ome, farm, street	, factory, office build	ding, etc. 2	8f. Location (S		or Rural Route Number, City
Division or spital or Attending sours after death. neral Director: After filled in by the funer Certification:	4 Homicide determined	(Specify)				or rown, o		
	(Check only 1 Certifying Physici	an: To the best of my knowled: On the basis of examination a						
To the Ho within 24 To the Fu completel	29b. Signature and title of certifier	and manner stated.		29c. License n				(Month, Day, Year)
	Canalil	700 BE		O.C.M.			May 19, 201	
	30. Name and address of person who	completed cause of death /Item	23a)					
	Carol Allan MD Assista			more Street B	altimore MD	21223		

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Baby Girl Briddell 2015 Medical 4a. Fa Hty Name (if not institution, give street and number) Examiner 4b City, Town, or Location of Death 4c. County of Death s. last birthday) If Unde If Unde 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Hours Director infant 1 □ M 2 🔀 F Yrs. May 17, 2012 Maryland 28a-f show aţ 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits Director notified MD 1 🗆 Yes 2 😾 No Wicomico Parsonsburg 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 33823 Old Ocean City 21849 USA items ; ı "natural", or item edical Examiner π Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black White etc. 1 X Never Married 2 Married Completed by Yes Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Specify: black 3 Widowed 4 Divorced Year or Dates. is marked other than "natur aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) infant infant infant infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sierra Briddell Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Johns Hopkins Hospital 1800 Orleans Street Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Dother (Specify) in state Si nature Funeral Service Lice 22. Name and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or prheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a d Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): this certificate has been signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No 2 shoul be detached for Month Pregnant at time of death Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 \square Yes 2 $\sqrt[4]{0}$ No 3 \square Probably 4 \square Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? filled in by the funeral director, page performed? 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: ၉ 1 Yes 2 No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Deat Certificate: Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After Natural Accident 5 Pending 1 Yes Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29d. Date signed (Month. Day, Year) person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

MAY 3 0 2012

1800 OnLeavis Stree

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 23 11:20 AM May Cathleen A. Burkheimer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth Days Hours Min (Month, Day, Year) Director 214-56-<u>3476</u> 1 □ M 2 🛛 F Feb 19, 1950 Maryland 62 Usual Residence of Decede show 10a, State 10b. County filed within 72 hours efter death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 651 Gilbert Road 21001 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 A Married ğ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: white 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation un 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 clerical permit. Pege 1 end 2 should be filed w Department of Health and Mental Hygi Important: If Item 27 Is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rosalie Claudia Wilde John Worthington Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 651 Gilbert Road Aberdeen, MD 21001 19a. Informant's Name/Relationship (Type, Print) Paul Berkheimer/spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 N Donation 5 Other (Specify) his of Funeral Service Rotta 1 d Signi 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street Director 2 23a. Part 1. Ener the disease, or complications that caused shock, or heart failure. List only one cause on each line. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LUNG CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examine Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or mjory Due to (or as a consequence of) sician end burlal-transit or Attending Physician: The lew requires that the death certificete be executed that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical use es the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, pege 2 should be deteched for i in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No g | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Yes 2 X No 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Other: 4 Nursing Home 5 Residence 6 X Other (Specify) မှ 1 ☐ Yes 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Hospital of 24 hours at e Funeral D Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

(Check

only one) 29b. Signature and title

TRACIE L.

of certifie

MORCAN,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

2. Registrar's Sigr

a.m.

2012

BURKHEIMER

CATHLEEN

2300 DULANEY VALLEY RD.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The time, date and place, and due to the cause(s) and manner as stated.

icense number

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician/ 1:15 AM Constance A. Belz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Wicomico Haspice at the Lake - oastal 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8 Date of Birth Funeral Min Feb 4, 1920 1 □ M 2 🗓 F Maryland 214-14-2049 Director 92 Usual Residence of Decedent 28a-f shov is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Salisbury MD Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 1109 S. Schumaker Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 👿 No Specify: Specify: white 3 X Widowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2121 Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. 12 <u>homemaker</u> own home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Francis O'Toole Catherine Mary Panuska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Belz/son 3840 Lorcon Lane Arlington, VA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Signatur, of Lineral Service Licensee Ronal S. Wade State Anatomy Board 655 W. Baltimore Street prector MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Immediate Cause (Final CHRONIC Onset and Death Priysician 1DNZ DISBASTE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to for an a nonnectionne of if any leading to him ediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? page certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes HOSPICA ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After ' Natural 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death

To the Funeral Director. A

completed filled in by the f 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. -Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 10058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARUS 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY Shirley Ann Beard 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQUARE HOSPITAL ROSEDALE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. December 11, Hours Balt. Maryland Director 212-70-1861 1 ☐ M 2**XX**F 56 1955 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Parkville Baltimore Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? United States of America 21234 Completed by Funeral 2335 Foster Avenue items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner I 14. Race - American Indian. Black, White, etc. Armed Forces 2 X No 1 ☐ Never Married 2 🔀 Married Yes Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Shirley Louise Kuni ပ Jack Ronald McClure 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John Anthony Beard/husband 2335 Foster Avenue Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, cremetory or other place)
Moreland Memorial
Park 4 Donation 5 Other (Specify) 2012 Parkville, Maryland 22. Name and Address of Facility Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 f Funeral Service License Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Ph_sician/ RESPIRATORY disease or condition Medical resulting in death) **Examiner** SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE EXACERBATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed TOBACCO ABUSE the attending physician and Due to (or as a consequence of resulting in death) Last Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Unknown Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death

To the Funeral Lirector: A ter this certificate has I autopsy perform death? 1 ☐ Yes 2 ☐ No Yes npletely filled in by the fineral director, 25. Was case referred to medical Vital 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division of 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO RES0000 05/27/15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21237 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD YIP MD 31. Date filed Month, Day, 32. Registrar's Signature MAY 3 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registral Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 2012 Year Physician/ Buckner Tnez 1:25 P. 26 May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Harford 34 Idlewild Street Bel Air 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Carolina 1922 **Director** 242-20-0563 1 □ M 2 🛛 F 89 Dec. Yrs Usual Residence of Deced items 23a or 28a-f show ler must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21014 34 Idlewild Street Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc P Completed by 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or 1 Yes 2XXNo If Yes, Give Year or Dates. Specify: White 1 Yes XXNo Specify 3 X Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland ည Jennie Williams Barnett McIntosh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra once. 121 John Street Perryville, MD 21903 . Page 1 and 2 s ment of Health Kenneth Buckner / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 30, cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State Bel Air Mem. Gàrdens Bel Air, Maryland 4 ☐ Donatio 5 ☐ Other (Specify) 2012 uneral Servic 21. Signature Evans Funeral Chapel & Cremation Service-Bel Air 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Interval Between OBSTRUCTIVE PULMGNARY Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of) requires that the death certificate be executed attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Box in the past 12 poinths?

1 Yes 2 No Month Dav Year 1 Yes 2 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No Records, 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law has autopsy performe Director: After this certificate 2 🗌 No Yes Yes filled in by the funeral director, 25. Was case referred to medical **Division of Vital** Certificate; To Be 26. Place of Death (Check only one, examiner? Other: 2 No 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 2 🗌 No 1 Yes Investigation
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nursa Practitioners To the best of my hirovilledge 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Mav Month 28^{Day} Physician/ Francis John Baker, Sr. 2012 12:00 PW Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death

Baltimore County 4b. City, Town, or Location of Death **Examiner** 13615 Pleasantville Road Baldwin 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** Months Days Hours 212-32-5939 1**≭**1 M 2 □ F **Director** 77 Yrs Jan. 30, 1935 Baltimore, MD. Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 XNo Baldwin 28a-f Baltimore County Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Count ō 21013 United States Funeral 23a 13615 Pleasantville Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status ral", or iten Examiner Armed Forces Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. ğ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: White Specify "natural", Completed 3 X Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) alth and Mental Hygiene.
27 is marked other than r traumatic event, the M Assembly Worker General Motors Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Hager ပ Francis Charles Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baldwin, Maryland 21013 13615 Pleasantville Road Health tem 27 Ms.Minette Vendetti (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Department of F Important: If ite any injury or oth (Harford County) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Fureial Chapel and Wednesday Forest Hill, Maryland May 30, 2012 4 ☐ Donation 5 ☐ Other (Specify) Cremation Services, Inc. en effrey L.Gair,Sr.OS ²Percential Afternatives Funeral and Cremation Center, P.A. Timonium, Maryland 21093-2215 Lic.#M00677 2325 York Road 23a. Par . Exter the dis shock, or hear fail. Immediate Cause (Final polications that caused the death. Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death should be detached Unknown the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 death? 1 Yes 2 No this certificate Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital 2 No Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending injury 1 Yes 2 No M Investigation Accident ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month. Daf. Year) Chesapeake Pr State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				partment of Health and I	Mental Hyg	iene	
				Certificate of Death		Reg. No. 2012 6	
Е	Physicia		1. Decedent's Name <i>(First, Middle, Last)</i> Catherine Bassin		2. Date of Death		3. Time of Death 10:45a M
may.	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of	
			16 Mountain Road	Linthicum Height		Anne A	
	Funeral Director		5. Social Security Number $090-30-2256$ 6. Sex 7. Age (In yrs. last birthda $1 \square \text{ M 2 N} \text{ F}$ 73 $_{\text{Yrs}}$	Months Days Hours Min.	(Month, Day,	Year)	Birthplace (State or Foreign Country)
		9.1	Usual Residence of Decedent		Aug.31,	1938	New York
	aryland a-f sh fied a	Director	10a. State 10b. County 10c. City, Town or Maryland Anne Arundel Linthicu	m Heights			10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	the Ma or 28, e noti		10e. Street and Number	10f. Zip Code	1	0g. Citizen of Wh	
	s 23a	Funeral	16 Mountain Road	21090	Ţ	JSA	
	r death ir item iner n		Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)		- American Indian, White, etc.
930	s after ral", o Exam	q pe	1 ☐ Never Married 2 💢 Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Year or Dates.	1 ☐ Yes 2 X No Specify:		Specify: \	white
2-0	2 hour	plet		ecedent's Usual Occupation ive kind of work done during most of work	king	16b. Kind of Busi	iness/Industry
121	rithin 7 iene. r than the Mu	Completed by	Elementary/Secondary (U-12) College (1-4 or 5+)	e. DO NOT use retired) ne Maker		Own	Home
pu	filed wall Hyg	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nan	me (First, Middle, M	aiden Surname)	
ylaı	uld be f Menta narked natic er	Jo	George Moretti	Helen E			
, Mai	nd 2 sho ealth and m 27 is r	80	19a. Informant's Name/Relationship (Type, Print) Martin Bassin / husband 19b. M	ailing Address (Street and Number or Rui Mountain Road Lint	hicum He:	ights,Ma	te, Zip Code) ryland 21090
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	sposition (Name of crematory or other place) Cematory, Inc. 5/29	I .		Sity or Town, State
Balti	permit. I Departin Importa any inju		21. Signature of Funeral Service Licensee Stephanie Custer	22. Name and Address of Facilit Crea 299 Frederick Road	mation So Baltimon	ociety o	f Maryland, Inc. and 21228
П		П	23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate
	hysician/	8 9	Immediate Cause (Final disease or condition	y serg			Get and Court
	Medical Examiner		resulting in death) Due to (or as a consequence of):	1			1
	- =	dical Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
B	ecutec and I-trans		Cause (Disease or injury that initiated events resulting in death) Last				
09	ate be executed ohysician and the burial-transit		d				
9289	tificate ing phy e as th	Med	IF FEMALE:				
Box 6	attending p		23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date Month	
Ö.	the de	hysi	1 Yes 2 o 4 Pregnant at time of death 9 Unknown 9 Unknown) — Other (speeding)			
s, P.O.	ires that the dea signed by the a Id be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tob	_	ute to the cause of death?
ord	tw require ts been si 2 should	Completed			24a. Was an		ere autopsy findings available or to completion of cause of
Rec	rsician: The law I	Com			perform	ned? dea	ath?
ital	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Ves 2 A March 1 Pospital:	26. Place of Death (Chec	1		
of V	g Physer this peral d	te: To	27. Mann of Death 28a. Date of injury 28b. Time	tient 3 □ DOA 4 □ Nursing H e of 28c. Injury at	ome 5 Resider 28d. Describe how		
Division of Vital Records,	tendin leath. or: Aft the fur	Certificate:	1 Natural 5 □ Pending (Month, Day, Year) injur 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	y work? M 1 \(\sum \) Yes 2 \(\sum \) No			
ivis	lor At after d Direct d in by	Cert	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Str. City or Town,		or Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death. To the Funeral Director: Affer this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier (Check only one) 1	vestigation, in my opinion, death occurred a	at the time, date and	place, and due to	o the cause(s) and manner stated.
	To the within 3 To the comple	4	29b. Signature and title Pertifier	29c. License number D L 60 94	1 43		Month, Day, Year)
	VQ		30. Name and address of person who completed cause of death (Item 23a) (Ilyp	3. Print) / Wind in	Pak	Down	A
	Stat		31. Date filed (Month, Day, Year) 82. Registrar's Signature	Mad	, , , ,	burn	. OG 2106
	Registra	ir	MAY 3 0 2012 June B. Jac				']

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Duane Richard Bowden May 9:45p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9214 Greenwood Lane Prince Georges Seabrook If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** (Month, Day, Year Months Days Hours **Director** 503-30-2181 1 🗶 M 2 🗆 F 73 March 27,1939 South Dakota 28a-f shov 10b. County 10c. City. Town or Location notified at Director 1 ☐ Yes 2 X No Prince Georges Maryland Seabrook 10f. Zip Code 0 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 20706 USA 9214 Greenwood Lane death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1051 Race - American Indian. Black, White, etc. 1951-X Yes 2 No Yes, Give 1 Never Married 2 Married and 2 should be filed within 72 hours after Completed by 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 1967 3 X Widowed 4 Divorced Year or Dates f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Saftey-Kleen Sales 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) ဂ Margaret Esther DeLashmett Russell Sherwood Bowden 19a. Informant's Name/Relationship (Type, Print)
Carolyn Flanders/step-daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4011 Parkwood Street Cottage City, Maryland 20722 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot Page 1 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 5/30/2012 Baltimore, Maryland Custer 22. Name and Address of Facility Cremation Society of Maryland. Inc. Signature of Funeral Service Licensee Stephanie 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death been signed by the should be detached g Unknown a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was ar page 2 autopsy death? performe 1 ☐ Yes 2 ♣No Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Certificate: X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) 29b. Signature completed cause of death (Item 23a) (Type, Print)

State Registrar 30. Name and address of pers

31. Date filed (Month, Day, Year

Peter

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3 0 2012

₩.D.

32. Registra 's Sign

DHMH 17 Rev 06-2011

7525 Greenway Cnt Dr. T-4, Greenbelt, Maryland 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 27, Billie Kathryn Barnard 10:20a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9282 Frederick Road Ellicott City Howard Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Nov. 17,1928 Hours 458-42-5420 83 1 □ M 2 🗓 F **Director** Texas Usual Residence of Deceden 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 XNo Maryland Baltimore Catonsville 5 10f. Zip Code 10g. Citizen of What Country? must be 23a 21228 USA 1002 Spring Gate Road, Unit 2A items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces2. 1 ☐ Yes 2 ⚠ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 0 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. "natural", Specify: white 3 X Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Geoligical Grafter Shell Oil Company traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Edna Gretchen Gilmore William Lundry Roche 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is nany injury or other the 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Held/Daughter 9282 Frederick Road Ellicott City, Maryland 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 5/30/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physicani disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transit physician and Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) resulting in death) Last Physician/Medical the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent prognant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ò Month Year Day Pregnant at time of death 5 Other (specify) the a Unknown g 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performe certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? daughter's residence Other: ၉ 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 K Other (Specify) 24 hours after death.

Funeral Director: After this er of Death 27. Man 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signa 29d. Date signed (Month, Day, Year) MD59437

Registrar

State

Sarah L.

31. Date filed (Month, Day, Year)

Street Baltimore, Maryland 21287

Caroline

Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

601 N.

32. Registrar

Clever, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 2012 4:45 Daniel R. Boyle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Lighthouse Assisted Living Ellicott City Howard Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) **Director** 516-24-5940 **№** M 2 🗆 F 83 June 5. 1928 Usual Residence of Decedent Montana show 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2X No Maryland Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9430 Northgate Road 20723 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, ed Forces?
Yes 2 No 1950 Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 1977 Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) 12 Military US Army Be Page 1 and 2 should be filed vent of Health and Mental Hygant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Albert J. Boyle Yvonne M. Chevigny other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1301 First Avenue #1005 Seattle, Washington 98101 Brian J. Boyle, Brother 20a. Method of Disposition
1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 105/29/12 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Immediate Cause (Final Onset and Death Ph i ian Prostate Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injurithat initiated events resulting in death) Last burial-tran nding physician and Due to (or as a consequence of) Physician/Medical P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year signed by the sid be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy performe 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manne of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No Accident Investigation completely filled in by the 6 \(\subseteq \text{Could not be} \) 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the set of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse The tittlement To the cause (s) and manner stated at the time date and place, and due to the cause (s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D47447 May 29, 2012

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who

MAY 3 0 2012

Andy Lazris,

31. Date filed (Month, Day, Year)

MD 6334

Cedar Lane Suite 103 Columbia, Maryland 21044

d cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 00:04 AM Edward Walter Batz 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Ag HOSDITH timore BA N/A If Under Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 216-36-2612 **Director** 1**X** M 2 □ F Yrs 72 July 6, 1939 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar many once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Baltimore Halethorpe Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 209 Fourth Avenue 21227 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 2 No 1955 þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 1961 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic Airport Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Charles Batz Audrey F. Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 Fourth Avenue Halethorpe, Maryland 21227 Helen Batz, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2X Cremation 3 Removal from State cemetery, crematory or other place, Metro Crematory Inc. | 05/30/12 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, 299 Frederick Road Baltimore, Inc. Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final -Ftysician/ disease or condition resulting in death) Medical Examiner Securitielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No Year Month Day Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy has After this certificate 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 은 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of Certificate: 28c. Injury at 1 Natural 5 Pending worl I Director: A 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) D73707 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S. CATON AVE, BAHIMER MD Zilbermint Mihai

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May Frank Jorg 2012 16:35P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Hours Director 515-70-9323 1 AM 2 F 50 Oct. 26, 1961 Germany Usual Residence of Decedent ns 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11403 Monteray Drive 20902 USA "natural", or items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. 0. Black, White, etc. Completed by 1 Never Married 2 X Married Yes Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: White If Yes, Give 3 🗌 Widowed 4 🗍 Divorced Year or Dates : 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. Fitem 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien Electrician Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Monfred Meurer Errika Bomm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Hardy - Stepfather 253 Harvey Haymon Rd., Leesville, LA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Byrial 2 N Cremation 3 Removal from State cemetery, crematory or other place 5-19-2012 4 Conation 5 Cher (Specify) Lambertown Cemetery Robeline, LA 22. Name and Address of Facility Metropolitan Funeral Service 21. Signeture of Fureral Service Licenses 5517 Vine Street, Alexandria, VA 22310 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hepatic Encephalopathy disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hepatocellular Carcinoma Sequentially list conditions, Examine Directo for the transportation of cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed End Stage Liver Disease that initiated events Due to (or as a consequence of): resulting in death) Last sician a Physician/Medical Division of Vital Records, P.O. Box 68760 physi the b the attending phone IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Month Day Year Pregnant at time of death 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 No death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 E 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? ours after death.

neral Director: Af

filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) May 17, 2012 D0067279

State Registrar 30. Name and address of person who complet

Suganthi Alagarsamy

1500 Forest Glen Road, Silver Spring, MD 20910

ed cause of death (Item 23a) (Type, Print)

Veerappan, MD

32. Rehistrar's Shart trace

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Randallstown Season's Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min Mo21/12/1962 1 🗆 M 2 🗆 F Massachusetts 033-36-1355 50 Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If the 21 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Cecil Rising Sun 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21911 USA 352 Fell Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes Ž☐ No Specify. 3 Widowed 4 Divorced Specify. White Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Healthcare should be filed with h and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Kenneth S. Studley Rita M. Schuckrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 Walnut Garden Road, Rising Sun, MD 21911 Joan M. Casaletto / Sister 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Chesapeake Crematory 5/29/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign to e of Funeral Service Liee uanto Maryland Cremation Services, PO Box 1413, Baltimore, MD 21203 mag . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrests, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ VER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be exec 24 hours after death. resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending E FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atte d be detached for in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown Part II<mark>. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performe 1 Yes 2 No 1 🗌 Yes 2 🕨 25. Was case referred to medical examiner? completely filled in by the funeral director, 26. Place of Death (Check only one) Be nos Hospital 1 Tes 2 No 4 Nursing Home 5 Residence မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 1 Matural 5 Pending injury Investigation Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State

To the I within 2 To the I

31. Date filed (Month, Day, Year)

only one)

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BUB

Registrar

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

15872 May 25, 2012 Alud Hen Bury p 2106/

12-03986 Derek Beach Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Concept State Concept Stat	Seren Beach	1- For State Registrar	Certificate of Death	Reg. No. 2012 16/5
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Modewid A Discrete Pres. Care Pres	uth with tems 23 st be not	11. Marital Status 12. Was Decedent Editor 1. Never Married 2. Married Armed Forces?	ver in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No- 14. Race - American Indian, Black,
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Pinysicial	MD d 2 sho lith and lith and art is numati	Michael D. Beach / Father	8901 Townsend Lane Clinton	n_MD 20735
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Sequentially ist cause (fine disease on each line. Part Part Comment Dep Dep B		Maryland Cremation Serv	vices PO Box 1413 Baltimore MD 21203	
Part Check only one Part		failure. List only one cause on each line.	52.1	Between Onset and
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29c. License number O.C.M.E. May 27, 2012 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	O, the exe sician a sucian a sucian a sucian a sucian a sucian a sucial -	□ AMENDED □ AMENDED 23a,		2 sm
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Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	CYCO	30 Name and address to M.		May 27, 2012
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar NAV 3 0 2012 August 6. August 6.	Office	Jack Titus MD. Deputy Chief Medical Exa	miner 900 W. Baltimore Street, Baltimore	, MD 21223
THE TAX PARTY OF THE PROPERTY		31. Date filed (Month, Day, Year) 32. Registrar's	Signature	

Physician/Medical 23c. If yes, outcome of pregnancy IF FEMALE: 23d, Date of delivery 3b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≨</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? ✓ Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined (Specify) 4 Homicide 29a. Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

The law requires that the death certificate be executed the attending physician ed for use as the burial -Division of Vital Records, P.O. Box 68760 has certificate Hospital or Attending Physician: this After within 24 hours after death.

To the Funeral Director: completely filled in by the fi

DHMH 17 Rev 1/2001 OCME 2006

Registra

Assistant Medical Examiner

30. Name and address of person who completed cause of death (fem 23a)

Russell Alexander MD. 31. Date filed (Month, Day, Year)

May 26, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BOSLEY 12:20P M ANN .201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 219-42-9591 Director 1 🗆 M 2 🔀 F 1931 Sept 9, Maryland 80 Usual Residence of Decedent 10d. Inside City Limits or 28a-f shown notified at 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 XNo Carroll MD Keymar 10g. Citizen of What Country? 10f. Zip Code items 23a or ner must be n ö 10e. Street and Number Funeral 21757 915 Francis Scott Key Highway United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status "natural", or iter Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes Give Completed 3 Divorced White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. 4 Housekeeper Nursing Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be Georgia Sweeden other traumatic Howard Bosley permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 915 Francis Scott Key Hwy. Keymar, MD 21757 Nancy King / Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) ☐ Burial 2 【XCremation 3 ☐ Removal from State inal Journey Crematory 5/29/2012 Woodbine, Maryland 4 Donation 5 Other (Specify) Sign of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Due to (or as a onsequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and burial-trai Due to (or as a consequence of): nding physician 14/monary dispu Physician/Medical Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten for u in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) the hed i Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Vunknown To the Hospital or Attending Physician: The law requires Division of Vital Records, Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed this certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Within 24 hours arter description 24 hours arter description. After the remains that filled in by the funer Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MD 21702 Tohnson State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:06 20/2 MA James Henry Brown, Medical 4a. Facility Name (if not institution, give street and number) Prince County of Death Examiner 4b. City, Town, or Location of Death illage andover 7. Age h yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 6. Sex **Funeral** Months Min Director 213-46-7185 1 X M 2 🗆 F 12/09/1942 69 Washington, DC Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 X Yes 2 No Hyattsville MD Prince Georges 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n Funeral 2424 Kent Village Place 20785 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Examiner Black, White, etc. ģ ō 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: "natural" 3 Widowed 4 X Divorced Completed Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) If Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Agriculture Farm Laborer 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o t. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked or ည traumatic Agnes Lee Washington Waldell George Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Brown / Daughter 2424 Kent Village Place, Hyattsville, MD 20785 Department of Health Important: If item 2: any injury or other t other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 05/24/2012 Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry MD 21076 7522 Connelley Dr., Ste. P, Hanover, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Arteriose Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the burial-trar and Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 L Fetal 400...
Pregnant at time of death Ectopic pregnancy in the past 12 months? Month Day Year be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed' 2 🗌 No 1 Yes Yes or Attending Physician: 25. Was case referred to medical Division of Vital filled in by the funeral director, Be 26. Place of Death (Check only one) examine? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 1- Natural 5 Pending work 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2012 Physician/ C. Brown \mathbf{P}^{M} Margaret May 27 11:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Essex 226 Commodore Drive 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 8. Date of Birth (Month, Day, Year, **Funeral** Days Hours Min 220-05-5016 Director 1 M 2 X F 93 August 30, 1918 Maryland Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 XNo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 226 Commodore Drive 21221 USA death with ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify White Specify: "natural", Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Baltimore County (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools Cafeteria Worker 7 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H ပ Elizabeth Sturmer Herman Sturmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Linda Hamel Daughter 226 Commodore Drive, Essex, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 31, 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Holly Hill Memorial Middle River, Maryland 2012 Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the diseas **Approximate** shock, or heart failure. List Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or a la consequence o **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami Cause (Disease or injury use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician dedecated for use as the burial Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Other (specify) 1 Yes 2 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown been sig should b 1 Yes 24a. Was an 24b. Were autopsy findings available page 2 prior to completion of cause of death? autopsy perform this certificate has performed? 1 Yes 2 No 25. Was case referred to medica examiner? funeral director, 26. Place of Death (Check only one) Be မ 1 🗌 Yes 2 No 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Certificate: After 1 Natural 2 Accident injury work? 5 Pending 2 🗌 No Investigation 24 hours after deat Funeral Director: filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nuyse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 Certifying Nu only one 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) 18612000 Name and address of person who completed cause of death (Item 23a) (Type, Print) #4105, Balt neve, MD Shaheen, 6701 N. Charles MAY 3 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ George Charles Boecker, Jr. 03: 02 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospita Baltimose St. Agnes If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) **Director** 1 🗶 M 2 🗆 F 80 Yrs. 216-28-1974 May 3, 1932 Maryland Usual Residence of Deceden 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 0a. State 10b. County at Director notified 1 Yes 2 No Baltimore City Maryland 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? ö Examiner must be 23a Funeral 21230 United States 3010 Lorena Ave. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. or 1 Never Married 2 Married þ Maryland 21215-0036 nan "natural", Medical Exan 1 Tes 2XXNo Specify. Specify: 3 XXVidowed 4 □ Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Elevator Machineist the permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the any injury or other traumatic event, the any lounce. 8th N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Myrtle Smith George Charles Boecker, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4090 High Germany Dr., Westminster, Maryland 21158 George Boecker, III / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery May 30,2012 Glen Burnie, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility 2719 Hammonds Ferry Rd., Lansdowne, Maryland 21227 21. Signa e of Fyn y al Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Aspigation Preumonitis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner eass Sequentially list conditions, Examine if any leading to immedicause. Enter Underlying Acute tubulas neciosis Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical 68760 the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Box (in the past 12 months? Month Day Pregnant at time of death been signed by the a should be detached 1 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alcohol abuse 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Vital 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be Other: 4 \(\text{\text{Nursing Home}} \) 1 \(\text{Residence} \) 6 \(\text{\text{Other}} \) Other (Specify) 1 Yes 2 **N**No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending within 24 hours after death.

To the Funeral Director. Aft completely filled in bear. Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD May P25499 24 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

900

32. Registrar's Signature

Nadipelli

31. Date filed (Month, Day, Year)

MAY 2 9 2012

Caton Avenue Baltimoje MD 21279

4	2 02005	
- 1	2-03905	

Steven Kearney Badeaux

Physician/

Medical Examiner

1- For State

1. Decedent's Name (First, Middle,Last)

Steven Kearney Badeaux

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		4a. Facility Name (i		n, give street and n	umber)				c. City, Tov Hagers		ocation of	Death			4c. County of Washing		
Funeral Director	- 1	5. Social Security N 212-54-(6. Sex	7. Age	(In yrs. Ia	st birthday)	rs.	If Under Months	1 Year Days	If Under Hours		8. Date of 0 2 / 1			9. Birti Foreig Cou	hplace (State or n Wash
und show aoy		Usual Residence of 10a. State MD	10b. County	ington			Town or Loc gerst								-		10d. Inside City
the Maryland is or 28a-f shortfied at 0000		10e. Street and Nur 487 Mit		l Avenue)				10f. Zip C 217					_	Citizen of Wha	at Coun	try?
fter death with 1", or items 23 10 must be no		11. Marital Status 1 Never Marrie 3 Widowed		arried 12. Was De Armed F 1 Yes orced If Yes, Give Ye or Dates:	orces?	Ever in U.S		f Yes		Cuban, I	Mexican, I		cify Yes or tican, etc.)	No-	14. Race White,	, etc.	can Indian, Black hite
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other trannatic event, the Medical Examiner must be notified at socce. To Ba Compileded by Europea Discretor	u biereu p	15. Decedent's Ed		cify only highest gra	1-4 or 5		16a. Deced during	mos	st of working	ng life. [OO NOT u	se retire	ork done ed)		b. Kind of Bus		
21215-0036 uid be filed within 7 Mental Hygiene. marked other than c event, the Medica	500	17. Father's Name (Last) Badeau	ζ					18			First, Middl Cros		len Surname)		
MD 21 d 2 should I lith and Mee n 27 is man	2 [19a. Informant's Na Meda Jo			ste	r									, City or Town raden		Zip Code) FL342
Baltimore, I bernit. Pages I and Department of Heal Important. If tem injury or other tra		20a. Method of Disp 1 Burial 2 5 4 Donation 5	X Cremation		rom Sta	te c	lace of Disp rematory or lanti	othe	er place)			5/2!	Date 5 / 1 2		Glen l	•	Town, State nie MD
Baltir permit. J Departm Imports	J	21. Signature of Fu	neral Service	Licensee		-	- ∦g	[h	me and Ad	All	.enP	A 70	090 F	Rid	ge RD	На	Fun S
Physician /Medical	Ī	23a. Part I. Enter th failure. List on Immediate Cause (ly one cause	on each line.										arrest, s	shock, or hea	rt	Approximate In Between Ons Death
Examiner		or condition resulting	ng in death)	Due to (or as				7	CIAC	F-1.3			7.2.011				
ted Insit		Sequentially list con if any, leading to im- cause. Enter Under (Disease or injury to	nmediate orlying Cause	Due to (or as												0	
cuted cuted and transit	EX3	events resulting in	death) Last	Due to (or as													
50, te be exe sysician a		X UNPENDED		AMENDED 23c. If yes,	-			pe	r me,	,g93	0 8-9	9–12	sm	T	23d. Date of c	delivery	
lox 68760, eath certificate be executed attending physician and for use as the burial - transit	Siciani	23b. Was decedent past 12 months	?	1 Live	birth nant at t	time of dea	2		l death er (Specif)	3 [Ectopic _I	pregnan	cy		Month	D	oay Yea

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day, Year)

fd 5-22-12

Foreign Wash D.C /1949 10d. Inside City Limits 1 Yes 2 X No g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. White Specify: 16b. Kind of Business/Industry Prefab Homes laiden Surname) ber, City or Town, State, Zip Code) Bradenton FL34203 20c, Location - City or Town, State Glen Burnie MD ty Crem & Fun Serv dge RD Hanover MD st, shock, or heart Approximate Interval Between Onset and Death

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 V Unknown

death?

subject ingested ethylene glycol

May 23, 2012

28f. Location (Street and Number or Rural Route Number, City or Town, State) 487 Mitchell Ave. Hagerstown, MD.

29d. Date signed (Month, Day, Year)

1 🗸 Yes

24b. Were autopsy findings available

prior to completion of cause of

24a. Was an

26.Place of Death (Check only one)

OCME

28c. Injury at Work?

29c, License number

O.C.M.E.

1 Yes 2 X No

autopsy performed'

✓ Yes 2 No

Other Nursing Home 5 Residence 6 🗸 Other: Scene

28d. Describe how injury occurred

Year

2 No

3. Time of Death

1226 hrs

Reg. No

2. Date of Death

Month Day May 22, 2012

Division of Vital Records, P.O. Box To the Hospital or Atteoding Physiciae: The law requires that the death. within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u

2

pleted

Com

Be

25. Was case referred to medical

2 No

Pending

6 Could not be determined

Investigation

examiner?

1 Yes

27. Manner of Death

1 Natural

2 Accident

3 X Suicide

Homicide

4

Medical 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Year)

and manner stated

ORIGINAL

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of Injury

fd12:26pm

Townhouse/Rowhouse

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of Injury - At home, farm, street, factory, office building, etc

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Baker Physician/ ances Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Iniversity of Mazyland Medical Center Baltimore 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 219-34-0864 73 Director 1 M 2 F 6/22/1938 MD 10c. City, Town or Location 10d. Inside City Limits be notified at Director 28a-f 1 Z Yes 2 No Adams PA Aspers 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 619B Bull Valley Road 17304 permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonee. 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Specify: White 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Grocery Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ludelle Frances Harrison Norman Leroy Leatherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 619B Bull Valley RD., Aspers, P.A 17304 Donald Baker-husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/30/2012 Sykesville Lake View Mem. 21. Signature of Paneral Service Licensee 22. Name and Address of FacilityFletcher Funeral Home, P.A 21157 Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death severe metabolic Immediate Cause (Final Physician/ acidosis disease or condition resulting in death) Medical Examiner sistent if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner -trar resulting in death) Last burial Be Completed by Physician/Medical P.O. Box 68760 the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery in the past 12 month 1 Yes 2 No Day Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an . Were autopsy findings available prior to completion of cause of isc he mia el maric 2 🗌 No 1 Tes Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 ☐ Yes 2 No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne eath 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Latural
2 Accident
3 Suicide
4 Homicide injun work? 5 Pending s after death. 2 🗆 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral I

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 25, 2012 8:47 PM Karl Beetz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Timonium Baltimore 15 Hathaway Road Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **Director** 213-32-8115 1 🛛 M 2 🗆 F Yrs Nov. 22, 1921 90 Germany Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Funeral Director 1 🗌 Yes 2 🕱 No Md. Baltimore Timonium 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21093 USA 15 Hathaway Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 Yes 2 No Black, White, etc. or Completed by 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Machinist Domino Sugar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) id Mental I marked c ပ္ Johannes Beetz Margaretha **Kestil** 1 and 2 should be of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irmgard Beetz/Wife 15 Hathaway Rd. Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Department of I Important: If it any injury or of once. 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Hilltop Service Corp; 5/30/12 4 Donation 5 Other (Specify) Towson, Maryland Signature of Funeral Service Licen 22. Name and Address of Facility Ruck Towson Funeral Home, Imc. Towson, Maryland 21204 1050 York Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition OMGESTI Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events put to for as a conscubence Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ဥ 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Tyes Accident Investigation within 24 hours after death To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 950 232 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) RIDGEBROW RD STC 312 SPANGEMO 2(15) 913 State

/DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Dwain Bar	ndy	State of Maryland / D 1-For State Registrar	Department of Certificate of			g. No. 20	12 1676			
Physici		Decedent's Name (First, Middle,Last)			2. Date of Deat Month		3. Time of Death			
cal Exami	iner				May 21, 20	012	0017 hrs			
		Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center		4b. City, Town, or Location of Do Bel Air	eath	4c. County of De Harford	ath			
Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year If Under 24		h (MM/DD/YYYY) 9. I				
Director		215-72-4314 1XM 2_F	52 Yrs		Min. July 3	3, 1959 For	_{eign} ^{Country)} Virg i nia			
		Usual Residence of Decedent								
vfaryland 28a-f show any i at once,	ō	10a. State	c. City, Town or Locati Abingdon	ion			10d. Inside City Limits 1 Yes 2 X No			
Maryl 28a-1	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Co	ountry?			
h the		4028 Sharilynn Drive		21009		USA				
72 hours after death with the Maryland 12 hours ", or items 23a or 28a-f sho 12 Examiner must be notified at once,	neral	11. Marital Status 1 XNever Married 2 Married Armed Forces?		s Decedent of Hispanic Origin? es, specify Cuban, Mexican, Pu		14, Race - Am White, etc.	erican Indian, Black,			
er dea	Ξ	1 Yes 2 X	No		, ,	·				
ural"	ð	or Dates: 15. Decedent's Education (Specify only highest grade complete		Yes 2 No specify: t's Usual Occupation (Give kind	of work done	Specify: W	hite s/Industry			
2 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	ost of working life. DO NOT use	retired)	70b. Tand of Edomeo	o/madsiry			
Mental Hygiene. marked other than c event, the Medical	ď	10	Maint	tenance		Apartmen	t Rental			
ed wi fygier other	ပွဲ	17. Father's Name (First, Middle, Last)		18.Mother's Na	ame (First, Middle, M					
Id be filed within 72 ho fental Hygiene. sarked other than "nu event, the Medical Ex	Be	Pearry Raymond Bandy			ucille Ch					
and 2 should be filed within ealth and Mental Hygiene. fem 27 is marked other that traumatic event, the Medic	ဥ	19a. Informant's Name/Relationship (Type, Print)		Address (Street and Number						
alth an 27		Dana L. Bandy / Mother 20a Method of Disposition		Sharilynn Driv						
es 1 a of He If ite		1 Burial 2 Cremation 3 Removal from State	crematory or oth		Date	20c. Location - City	or Iown, State			
permit. Pages 1 a Department of He Important: If ite	111	Donation Other Specify:			5/29/2012	Bel Air	, Maryland			
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that injury or other traumatic event, the Medic	HJ,	I. Signature o l'heral ervice Li ensee				uneral Ho	•			
hysician	1,11	3a. Part I. Ent. The disease, or commissions that caused the c		317 Cokesbury R			yland 21009 Approximate Interval			
cuted nd mark transit	Examiner	or condition resulting in death) Due to (or as a consequence of):								
oe exe	dical	■ UNPENDED AMENDED 23a, 2	7,28a-f,pe	er me,g928 6-4-	·12 sm					
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live birth 4 Pregnant at time 9 Unknown	2 Fet of death 5 Oth	al death 3 Ectopic preder (Specify)	gnancy	23d. Date of delive Month	ery Day Year			
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The law requir cate has been s page 2 should	Completed				24a. Was ar autops perform	y prior to ned? death?				
certific	Bec	25. Was case referred to medical examiner?		26.Place of Death (Che	ck only one)					
hysic this c	P P	1 ✓ Yes 2 No	2 ER/Outpatient			Residence 6 Oth	er:			
After funers		27. Manner of Death 1 Natural 5 Deading (Month, Day, Year)	28b. Time of In		I	ow injury occurred	olf in			
Attend death. ctor:	Certification:	2 Accident Pending Investigation fd 5-20-1			presence	stabbed s e of polic	:e			
pital or At ours after d ieral Direct filled in by	Ħ	Suicide Could not be		t, factory, office building, etc.	or Town, Sta	ate) 1302 Cok	Rural Route Number, City			
	8	293 Certifier Cemet			Abingdo	n,MD.				
hours hours neral		(Check only								
he Hospita in 24 hours he Funeral	Sa	one) a Medical Examiner: On the basis of examination	or mreatigati	, opinion, acam occurre	caro mno, uare al	piaco, ana une (0 i				
To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Medical	and manner stated.		29c License number	·	29d Data signed (**				
To the Hospital within 24 hours To the Funeral completely filled	Medical	and manner stated. 29b. Signature and title of certifier		29c. License number	1	29d. Date signed (M				
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical	and manner stated. 29b. Signature and title of certifier	(11	29c. License number O.C.M.E.	1	29d. Date signed <i>(M</i> May 21, 2012				
To the Hospital within 24 hours To the Funeral completely filled	Medical	and manner stated. 29b. Signature and title of certifier		O.C.M.E.						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

isa Dara Brill	1- For State	State of Mary	rland / Departn Certific	nent of cate of		Mental H		eg. No. 20	112 1676
Physician/ Medical Examiner	LISA	DARA		BRILI			2. Date of Deat Month May 27, 20	Day Year D12	3. Time of Death 0404 hrs
Turneral Control	4a. Facility Name (if no 12 Strand Cou 5. Social Security Num		number) 7. Age (In yrs. last b		o. City, Town, or Lo Owings Mills If Under 1 Year	ocation of Death		4c. County of Baltimore	County
Funeral Director	215-78-014 Usual Residence of De	40 1 M XXF		Yrs.	Months Days	Hours Mir	10/5/ 10/15	1970 /1970	9. Birthplace (State or Foreign Country) MD
Azryland 28a-f show any 1 at once.	MD	BALTIMORE	10c. City, Tow	n or Location			17	og. Citizen of What	10d. Inside City Limits 1 Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked uther than "natural", ur items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 12 STRAI 11. Marital Status	ND COURT	Decedent Ever in U.S.		21117 Decedent of Hispa		pecify Yes or No	USA - 14. Race - /	American Indian, 8lack,
rs after death ural", nr iten miner must b	3 Widowed	Married 1 Yes 4 Divorced If Yes, Give or Dates: ation (Specify only highest g	/ear	1	s, specify Cuban, f Yes 2 No s Usual Occupatio	specify:		White, of Specify: WI	HITE
5-0036 led within 72 hour Hygiene. I uther than "natu the Medical Exam Completed	Elementary/Seconda	College 2	(1-4 or 5+)		st of working life. D	OO NOT use ret	ired)	BEAU'	ГҮ
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MD 21 ad 2 should alth and Mer m 27 is ma raumatic ev	19a. Informant's Name. SAMUEL	/Relationship (Type, Print) $ m BRILL~/~FATHE$	ZR	5 BR	ENTGATE (T; RANI	DALLSTOW	nber, City or Town, N. MD 21	133
Baltimore, location Pages I and Department of Heal Important: If item injury or other tra	4 Donation 5	Cremation 3 Remova	I from State crem	atory or oth EL MEI	MORIAL PK	5-	Date -29-2012		LSTOWN, MD
	21. Signature of Funer	al Service Licensee	t coursed the death. Do	- 1	O REISTE	. 201		ON & BROS	
Physician Medical Examiner	failure. List only of Immediate Cause (Fin- or condition resulting in	one cause on each line. al disease a. Narco	tic (morphings a consequence of):						Between Onset and Death
ner	Sequentially list condit if any, leading to imme cause. Enter Underlyi	ediate Due to (or a	s a consequence of);						
recuted 1 and - transit	(Disease or injury that events resulting in dea	initiated	s a consequence of):						
ë # # . =	X UNPENDED	X AMENDE	a,27,28 #8 crFH, G928		er me,g9 012,WS	28 6–13	-12 sm	23d. Date of de	elivery
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Division of Vital Records, I To the Impital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sig completely filled in by the funeral director, page 2 should be edical Certification: To Be Completed							1 ✓ Yes	rm <u>ed</u> ? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No
F Vital Physician: or this certifical director To Be	25. Was case referred examiner?	to medical Hospital: 1	Inpatient 2 ER	Outpatient		of Death (Check ther 4 Nursi		Residence 6	Other: Scene
Division of spital or Attending Plyours after death, meral Director: After if filled in by the funeral Certification: T		Pending Investigation fd	onth, Day, Year) 5-27-12 f	d 3:50	am 1 Ye	s 2 🗶 No	unknown		or Rural Route Number, City
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Division To the Huspital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		ertifying Physician: To the edical Examiner:On the bas and manne	sis of examination and/o	death occurr r investigati	on, in my opinion,	death occurred	d due to the caus at the time, date	and place, and due	s stated. e to the cause(s) 1 (Month, Day, Year)
	D-~)		,	29c. License O.C.M			May 27, 201	
pend	Donna M. Vind		t Medical Examine Registrar's Signature		W. Baltimore \$	Street, Balti	more, MD 21	223	
State Registra		0 2012 Jenn	. Logistral a digitature	Wal					
DHMH 17 Rev 1/2001 OCME 2006	I	OCME	, , , , , , , , , , , , , , , , , , ,	RIGINA	-				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marth 2 ³³ 20^Y1^a2 5:23 Evelyn Margaret Boone Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Manchester Longview Nursing Home Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 23 **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 Ty 212-05-0017 102 Maryland 1909 **Director** Usual Residence of Decedent 28a-f show Director 10a, State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🗓 No Maryland Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21102 U.S.A. 3209 Boone Drive within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Completed 3 ♥Widowed 4 □ Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 7. Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11 Homemaker Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Augusta Biddison Alfred Frederick Hinke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3209 Boone Dr. Manchester, MD.21102 Arthur Philip Boone, Jr.-soh Baltimore, t of Heal 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) May 30 pat 2012 . Page 1 permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Evergreen Mem. Gardens Finksburg, MD. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, MD. 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated experts) Exami The law requires that the death certificate be executed sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ending physician ause as the burial-Physician/Medical P.O. Box 68760 IF FEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 L Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No jo Pregnant at time of death Unknown g 🗌 Unknown ned by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1 ☐ Yes 2 ☐ No Yes **Division of Vital** or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes Other: 2 No 은 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral Certificate: 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Aft completed filled in by the fur 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

(Check

29b. Signature ar

Registrar

DHMH 17 Rev 7/2009

ORIGINAL

on who completed cause of death (Item 23a) (Type, Print)

M.D.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

4111 LOWER BECKEYSVILLE

0001290

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible.

		I- For State Registrar			Cei	rtificate (Hygiene	Reg. No	. 20		2	676
Physician Medical Examine	~	1. Decedent's Name (First, Corne	Middle,Last) 11 Rayn	ard E	3ooke	er				2. Date of Do Month May 8, 2	Day	Year		3. Time o	
		4a. Facility Name (if not ins Johns Hopkins Ho	-	and number)			y, Town, or Itimore	Location of De			c. County of N/A	Death		
Funeral Director		5. Social Security Number	6. Sex			ast birthday)		nder 1 Yea		Hrs. 8. Date of 1	,	1/DD/YYYY) 1965	9. Birth Foreign Cour	, ,	ate or
any	-	Usual Residence of Deceder 10a. State 10b. Co			10c. City,	, Town or Loc							T	10d. Insid	e City Limits
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the Maryland a or 28s-f sh iffied at once		10e. Street and Number 9923 Linde	n Hill	ВЧ				Zip Code 21117	7		10g. Cit	tizen of Wha		ry?	-
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Furneral Director	luera	11. Marital Status 1 Never Married 2	Married Ar	as Decedent med Forces?	?		Vas Dece	edent of His	spanic Origin?	(Specify Yes or Nerto Rican, etc.)	No-	14. Race - White,	America	an Indian,	Black,
s after de ral", or niner m	<u>5</u>		Divorced If Yes, C	Sive Year S:	X No			2 X No				Specify:			
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MD 21215-0036 1. should be filed within 7 th and Mental Hygiene. 1.27 is marked other than unatic event, the Medica To Be Comple	2	19a. Informant's Name/Rela Pamela Kin								Rd., (
ore, Nest and of Health If item	_	20a. Method of Disposition 1 Burial 2 Crem	nation 3 Rem	oval from St	ate (Place of Disporternatory or	other pla	ce)		Date		Location - C	•		
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		F FEMALE: 3b. Was decedent pregnant past 12 months?		f yes, outcon Live birth	ne of pregr		etal dea	th 3 [Ectopic pre	gnancy	23	d. Date of de	elivery		Year
b. Box 6876 the death certificate by the attending phy they for use as the liched for use as the Physician/M	13915	1 Yes 2 No 9	Lintenaum T	Pregnant at Unknown	time of de	ath 5 (Other (S)	pecify)	- 14						
D. Greed Jeets	\$.	Part II. Other significant co	enditions contribu	iting to death	but not re	esulting in the	underlyi	ng cause g	iven in Part I.			use contribu			
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84 87		Homicide 29a. Certifier (Check only) 1 Certifyir	ng Physician: To t	ne best of my	/ knowledg	ge, death occ				and due to the cau	use(s) ar	nd manner as	s stated.		
To the Howithin 24 F. To the Funcompletely		29b. Signal r and title of ce		pasis of exar nner stated.	mination ar	nd/or investig		my opinion 9c. Licens		d at the time, date		ace, and due			ar)
		/ lalo	Call					O.C.I	M.E.		1	y 9, 2012		,,,,	
	7	o. Name and address of pe Laron Locke MD.	rson who com the Assistant Me				altimo	re Stree	t, Baltimore	, MD 21223					
	e ³	31. Date filed (Month, Day, Y		32. Registrar	's Signatur										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #16b per FH G927 5/30/2012 JH. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 10:00 PM JOSEPH GEORGE CADDEN, SR 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Ranklin Square Hospital Baltimore Kose 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 213-32-3282 Director 1 🛚 M 2 🗆 F 76 May 18, 1936 Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified Maryland Baltimore 1 Yes 2XXNo Baltimore County 10e. Street and Numbe 0 10f. Zip Code 10g. Citizen of What Country? 23a must 4522 Fitch Avenue 21236 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? ↑X Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1954-57 White 1 Yes 2 X No Specify. Specify 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Police Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Lt. - Balto. City Police Dept. Prolice DEpt. 12 yrs 2 vrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aloysius Patrick Cadden Catherine Mildred Moenuis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4522 Fitch Avenue Baltimore, Md. 21236 Patricia A. Cadden (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Parkwood Cemetery 5-30-2012 Baltimore, Md. 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Pneumoni Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Atrial Fibrillation Exami the burial-transit Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atter in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Replacement Valve 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 N 2 🗌 No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 1 \square Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sha 9000 Franklin Baltimore MD 21237 iKh Square Drive, Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Joseph

12-03956 Andre Curry			e or Print in Black l e of Maryland / Dep					gible.	
,		1- For State Registrar	Ce	ertificate o		ia montari		g. No. 201	2 1677
Physicia Medical Exami		1. Decedent's Name (First, Middle, L Andre SAM	/	JR.			2. Date of Death Month May 24, 20	Day Year	3. Time of Death 2035 hrs
		4a. Facility Name (if not institution, Johns Hopkins Hospital	give street and number)		4b. City, Town, o Baltimore	or Location of Dea		4c. County of Death	
Funeral				. last birthday)	If Under 1 Ye		/	th(MM/DD/YYYY) 9. Bird	in
Director		217-06-4708 1 Usual Residence of Decedent	⊠ M 2□ F	28 Yrs		ys Hours III	01/13/	1984 0	untry) MD
w any		10a. State 10b. County		ty, Town or Locat					10d. Inside City Limits 1 X Yes 2 No
Aaryland 28a-f show	Director	M D 10e. Street and Number		BATIMO	10f. Zip Code		10	Og. Citizen of What Cour	
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.			RAL AVENUE			202		USA	
eath wit items 2 ust be n	Funeral	11. Marital Status 1 Never Married 2 Marri	12. Was Decedent Ever in Armed Forces?			ispanic Origin? (an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
after d	Dy F		1 Yes 2 No ed If Yes, Give Year or Dates:		Yes 2 N			Specify: BL	
2 hours		 Decedent's Education (Specify Elementary/Secondary (0-12) 	College (1-4 or 5+)			ation (Give kind o e. DO NOT use re		16b. Kind of Business/I	1
215-0036 be filed within 7 atal Hygiene. riced other than ent, the Medica	Completed	12		TRA	USPORT			TRANSPOR	ETATION
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e, MD and 2 sho fealth and item 27 is traumati		19a Informant's Name/Relationship TAMELA JACK 20a. Method of Disposition	SON / WOTHER	Place of Dispos	tion (Name of ce	emetery,	Date Date	20c. Location - City or	10 · 2/202 Town, State
imore, Pages 1 an nent of Hea ant: If ite		1 Burial 2 Cremation 4 Donation 5 Other Spec	Removal from State	crematory or oth	nerplace) MoRIA	2 6,	1/2012	BAITIMO REENE FUNE	RE, MD
Baltil permit. Departm Imports		21. Signature of Funeral Service Lic	ensee Mod CC3	22. N	ame and Addres	ss of Facility V	AUGHN 6	REENE FUNE	CRAL SCYS
Physician	┪	23a. Part I. Enter the disease, or colfailure. List only one cause on	mplications that caused the deat	th. Do not enter th	e mode of dying	, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/ /Medical Examiner		•	a. Multiple Gunshot Wou						Death
*		Sequentially list conditions,	b						
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ransit - transit	Exa	events resulting in death) Last	Due to (or as a consequence d.	of):					
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58760 rtificate ling phy	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	2 Fet	al death 3	Ectopic pregr	nancy	23d. Date of delivery Month D	ay Year
Box 68760, re death certificate be the attending physicined for use as the burined	Physician/Med	1 Yes 2 No 9 Unkno	wn 9 Unknown	leath 5 Oth	ner (Specify)				
that the oed by detach	by P	Part II. Other significant condition	contributing to death but not	resulting in the u	nderlying cause	given in Part I.		pacco use contribute to t	
rds, requires	Completed						24a. Was ar	n 24b. Were eut	opsy findings available ompletion of cause of
Division of Vital Records, tal or Attending Physician: The law requirers after death. **I Director: After this certificate has been sited in by the funeral director, page 2 should the company of the funeral director, page 2 should be applied in the funeral director.	ошо						perform	ned? death?	
ician: ician: s certifi	8	25. Was case referred to medical examiner?	Hospital:	✓ ER/Outpatient		Other Nurs		Residence 6 Other:	
of V ng Pbys	n: To	1 Yes 2 No	28a. Date of Injury (Month, Day, Year) May 24, 2012	28b. Time of Ir		ıry at Work?		ow injury occurred	
Sion Attendi	catio	1 Natural 5 Pending 2 Accident Investig		2000 hrs		Yes 2 No		treet and Number or Rur	al Boute Number City
Division Hospital or Attend 24 hours after death, Fruneral Director: etely filled in by the 1	Certification:	3 Suicide 6 Could no determin	ot be		i, lactory, office i	bunding, etc.	or Town, Sta		
Division of Vital Records, P.O. Box 68760, vithin 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical C	(5115011 0111)	ician: To the best of my knowle er:On the basis of examination						
To with	Æ	29b. Signature and title of certifier	and manner stated.		29c, Licens	se number		29d. Date signed (Mon	th, Day, Year)
		Yangla? with	hall MD		O.C.	M.E.		May 25, 2012	
2		30. Name and address of person wh Pamela E. Southall, MD			W. Baltimor	e Street, Balt	timore, MD 21	223	
Sta Regist		31. Date filed (MMH, Vay3°0) 2	32 Registrar's Signa	1. bar	20	_			
regist	-		4-4-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g928 6-11-12 vt.
State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Norman Carroll Day 30A 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore tos . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1929 9. BirthplacevState or Foreign **Funeral** Director 1 XM 2 □ F 82 Yrs. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23° ~ ~ ~ any injury or other traumatic event, the Martin one. 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Baltimore 1 Tes 2 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 5. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 2 Yes 2 If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ 2 No 1 🗆 Yes 2 📉 No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surname) ၉ arro or Rural Boute Number, City or To ant's Name/Relationship (Type, Prir wn, State, Zip Code) 19b. Mailing Address (Street and Number BAlto 5620 GRANdson 11. JOHNSON 20b. Place of Disposition (Name of celenetery, crematory or other 20a. Method of Dist 20c. Location - City or 1 Burial 2 Cremation 4 Donation 5 Other (S 3 Removal from State 21. Signature of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Lung cancer disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 4 Nursing Home 5 Residence 6 other (Specify) 2 No 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28h Time of 28d. Describe how injury occurred Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation To the Hospital or Attention within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NSTajapathLMD 00057465 5/23/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltinore MD 21209 N 3 Kajapakse MD \$ 203 2835 Smilh /N State Registrar

2-04047	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
oann Mary Coffman	State of Maryland / Department of Health and Mental Hygiene	2012
4 Eng State		/ 11 1 /

	1- For State Registrar	Certificate d	of Death	Reg. N	o. 201	2 101
Physician Medical Examine	Joann Ma	ary Coffman		2. Date of Death Month Day May 28, 2012	/ Year	3. Time of Death 1345 hrs
	4a. Facility Name (if not institution, give st 1852 Marshall Road	reet and number)	4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore Cou	
Funeral Director		7. Age (In yrs. last birthday) 2.4 F 53 Y	If Under 1 Year If Under 24Hrs Months Days Hours Min	_ `	M/DD/YYYY) 9. Birt 7,1958 Foreig Cou	hplace (State or nuntry) Maryland
ath with the Maryland items 23s or 28s-f show any ast be notified at once.	Usual Residence of Decedent 10a. State 10b. County Md. Baltime	ore 10c. City, Town or Loc	Dundalk			10d. Inside City Limits 1 Yes 2 No
the Maryland sa or 28a-f sh			10f. Zip Code 21222	10g. C	itizen of What Coun USA	try?
ral", or	3 Widowed 4 Divorced If Y	Armed Forces? If Yes 2 No es, Give Year Dates: 1	Vas Decedent of Hispanic Origin? (Si Yes, specify Cuban, Mexican, Puerto Yes 2 No specify: ent's Usual Occupation (Give kind of v	Rican, etc.)	14. Race - Americ White, etc. Specify: Kind of Business/Ir	hite
5-0036 led within 72 hour lygiene. other than "natu the Medical Exan	Elementary/Secondary (0-12) 12 years	red)	Own Hor			
215-0 be filed v ntal Hygi rrked othic ent, the l		ison		(First, Middle, Maide CCormick	n Surname)	
MD 21215-0036 12 should be filed within 7 12 should be filed within 7 127 is marked other than umatic event, the Medica To Be Comple	19a. Informant's Name/Relationship (Type Ralph C. Harrison	Print) 19b. Maili Father 2 Tr	ng Address (Street and Number or F elawny Court, Lut	Rural Route Number, Cherville,	City or Town, State, Md. 2109	Zip Code)
드스이트니	20a. Method of Disposition 1 Burial 2 X Cremation 3 4 Donation 5 Other Specify:	Removal from State crematory or or Bayview	Crematory 2	ne 2, 012 Ba	Location - Cify or Taltimore,	Maryland
Balti permit. Departm Importa	21 Signature of Fineral Service Licenses	The contract of	Name and Address of Facility Connelly Funeral 7110 Sollers Poin	t koad, Du	indalk. Mo	A. 21222
Physician /Medical Examiner	23a, Part I. Enter the disease or complicate failure. List only one cause on each I Immediate Cause (Final disease a Hy or condition resulting in death)	ions that caused the death. on not enter ne. drocodone Intoxica:	the mode of dying, such as cardiac o	r respiratory arrest, sh	nock, or heart	Approximate Interval Between Onset and Death
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ted Insit	if any, leading to immediate Due cause. Enter Underlying Cause (Ulsease or Injury that initiated events resulting in death) Last Due	to (or as a consequence or):				
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760, cate be executed physician and the burial - transi	IF FEMALE: 2	3c. If yes, outcome of pregnancy	ет ше, дээо 0-э-12	-	3d. Date of delivery	
box 68760, the death certificate be by the attending physic ched for use as the burn Physician/Med	1236. Was decedent pregnant in the	Pregnant at time of death 5 0	etal death 3 Ectopic pregna other (Specify)	ncy	Month Da	ay Year
S, P.O. uires that the an signed by the detached by PPI		tributing to death but not resulting in the	underlying cause given in Part I.	1 Yes 2		bly 4 🗸 Unknown
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as edical Certification: To Be Completed by Physician				24a. Was an autopsy performed?	prior to co death?	opsy findings available mpletion of cause of
F Vital F Physician: r this certifical director, To Be C	25. Was case referred to medical examiner? 1 Yes 2 No	tal: 1 Inpatient 2 ER/Outpatien	26.Place of Death (Check of the 3 DOA Other Mursing	nly one) Home 5 Reside	ence 6 🗸 Other:	Scene
on of anding Pt. r: After r he funeral	27. Manner of Death	28a. Date of Injury (Month, Day, Year) 28b. Time of fd 5-28-12 fd 13 :	4 - Yes o - N-	28d. Describe how inj subject in		drocodone
Division of ¹ Hospital or Attending Ph 24 hours after death. Funeral Director: After tely filled in by the funeral al Certification: T	2 Accident Investigation 3 X Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, stre (Specify) Single Far	pet, factory, office building, etc.	28f. Location (Street a	and Number or Rura	I Route Number, City
To the Host within 24 he To the Fun completely Medical C	CertifyIng Physician: one) 2 Medical Examiner:On	Fo the best of my knowledge, death occu the basis of examination and/or investige manner stated.	ation, in my opinion, death occurred at	the time, date and pla	ace, and due to the	cause(s)
	29b. Signature and title of certifier 30. Name and address of person who comp	4 Teyley	29c. License number O.C.M.E.	A AE	y 29, 2012	ı, Day, Year)
0	Theodore M. King, Jr., MD.	Assistant Medical Examiner	900 W. Baltimore Street, Ba	altimore, MD 212	223	
State Registrai		32. Fighting's Signature	uel			
DHMH 17 Rev 1/2001	MAI 3 TO LOTE	ORIGINA	AL.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per fh g928 6-5-12 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alberta J. Collins Month May 27, 2012 Year 4:15 PM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **Transitions Nursing Home** Sykesville Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) Sep 27, 1928 **Funeral** 9. Birthplace (State or Foreign Months Days Min 220-24-8659 83 Country) MD **Director** 1 🗆 M 2 💢 F or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director MD **Baltimore City Baltimore** 1 Yes 2 No 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 4211 Massachusetts Ave 21229 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Yes If Yes, Give Year or Dates White 1 ☐ Yes 2 ♠ No Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. other than " within 7 Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress **Textile** of Health and Mental Hygie item 27 is marked other other traumatic event, the Be Page 1 and 2 should be filed vertent of Health and Mental Hygant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Odus Clinton Rohrback Mary Catherine Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4211 Massachusetts Ave Baltimore, MD 21229 Grover Collins Husband 20a. Method of Disposition

Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 9 cemetery, crematory or other place)
Crest Lawn Memorial Gardens Department or Important: If any injury or Jun 02, 2012 Marriottsville, Maryland 4 Donation 5 Other (Specify) nature of Funeral Ser ^{22. Name} Siack Fünera Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the dis ase, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arr Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ CRII Carcinoma disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of, burial-transif the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 🗌 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 2 No Accident the Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D57722 M.D.

DHMH 17 Rev 06-2011

State Registrar LEONARD

1838 GREENE TREE RUAD #300

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

RICHARDSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charles Albert Chalone Jr. MAY 28^y. 2012 7:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year if Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Hours **Director** 214-18-1156 1**X** M 2 □ F Yrs. 90 June 25, 1921 Marvland Usual Residence of Decedent 28a-f shov 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 X No Harford **Jarrettsville** Maryland ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2801 Rocks Road 21084 or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give Year or Dates. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "1 life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 <u>Office Clerk</u> Library Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Charles Albert Chalone Sr. Marie (nmn) Masilek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a tant: If item 27 is Barbara C. Ensor / Personal 2801 Rocks Road, Jarrettsville, MD 21084 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If ii any injury or o 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Rose Hill Svcs, LLC 4 ☐ Donation 5 ☐ Other (Specify) 5-31-12 Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, o Funeral Service Licenses 50 W. Broadway, Bel 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASCV D disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires Thoracio andre 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐No 24a. Was an autopsy performed' funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 332297 may 27,20%

State Registrar 21014

BEL AIR, MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day; Year)

615 W. MACPHAIL ROAD

32. Registrarts Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year 2:30A Kathrine Agatha Cashman May 26 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Westminster Ridge Carroll Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) 5-15-1925 219-14-8442 87 **Director** Yrs MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 505 High Acre Dr. 21157 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, ģ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3₺ Widowed 4 □ Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) Clothing 11 Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H John Waltz Edna Lindsay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157 permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other trau Jill Cashman-daughter-in-law 1205 Old Westminster Pike,Westminster,MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Evergreen Memorial 5/30/12 4 ☐ Donation 5 ☐ Other (Specify) |Finksburg,MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityFletcher Funeral Home 254 Ε. Main St., Westminster, MD 21157 23a. Par 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition D Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) SJ ObTEN Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 **N**o မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie F 17228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite wastminster 120 31. Date filed (Month, Day,

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Raymond Creighton Month Year 2012 8:42 Medical Мау 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Greater Baltimore Medical Ctr Towson Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Months Days 296-09-7595 94 Director 1 X M 2 □ F May 18 1918 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore Towson Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 Chestnut Avenue U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 X Yes 2 Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 XNo Specify: If Yes, Give Specify: White 3 X Widowed 4 Divorced Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (3-4 or 5+) Plumbing Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Creighton Alice Kredell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1222 Clearfield Circle Lutherville, Md. 21093 Dave Creighton / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If it any injury or of once. 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley MemGdns | June 1 2012 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Source Literal 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, Day to (or as a consequence on) cause. Enter Underlying Cause (Disease or injury Exami and as the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ signed by the atter d be detached for in the past 12 months?

1 Yes 2 No Month Year Day 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 LYes 2 □ No 3 □ Probably 4 □ Unknown tor: After this certificate has been si the funeral director, page 2 should I 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 1 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 No Other: ျှ 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 30. Name and address of person who completed cause of State

DHMH 17 Rev 06-2011

Registrar

12-03789 William L. Clark Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		4a. Facility Name (if not instituti		ımber)		4b.	City, Tow	n, or Lo	cation of	Death		4c. C	ounty of Dea	th	
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	4			7. Age (In yrs. la	et hirthday)	_	If Under 1	Year	If Under	24Hrs.	8. Date of B	rth (MM/DE	/YYYY) 9. B	irthplace (State or	
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MD 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 17 is marked other than "natural", or items 23s or 28s-f she umatic event, the Medical Examiner must be notified at once	유			E_							imore				
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f Vid Physic er this eral din	T	27. Manner of Death	28a. Da	ite of Injury	28b. Time	of In	jury 28	Bc. Injur	y at Work	?	28d. Descrit	e how inju	ry occurred		
n of ding Pl	Ö	4 🖘	ending (Mo	nth, Day,Year)			- 1	1 Y	'es 2	No					
tten death y the	ati		timotion	lace of Injury - At I	hama form i	atroot	factory	office h	uilding et		28f Locatio	(Street ar	nd Number or	Rural Route Number, City	
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the ras after death. Tal Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	iffic		ould not be	lace of injury - At I	nome, ram, s	suee	i, lactory,	onice b	unung, c			, State)			
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying	Physician: To the i	est of my knowle	dge, death o	ccurr	ed at the t	ime, da	ite and pla	ace, and	due to the c	ause(s) and	d manner as	stated.	
the hin 2	Medical	one) 2 Medical I	Examiner: On the bas	is of examination	and/or inves	tigatio	on, in my	opinion	, death or	curred a	tine time, da				
To wit	ĕ	29b. Signature and title of cer		a atatou.			29c.	Licens	e number			29d. [Date signed ((Month, Day, Year)	
		D 20	11 11 100	λ				O.C.	M.E.			May	18, 2012		
		Yamela Ter	Thoul, 14)											
		30. Name and address of per				000	W Pa	timo-	a Strac	t Raltie	more, MD	21223			
		Pamela E. Southal		nt Medical Ex		900	vv. Dai	arror		, Dailli	1.010, 1410	- 1220			
S	tate	31. Date filed (Month, Day, Ye	ar) 32.	Registrar's Signa	ature	2									
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salind Ann Col		State of Maryland / Departm 1-For State Certific			Mental I	, .	2	012 1677
Physiciai edical Examin	n/	1. Decedent's Name (First, Middle,Last) Rosalind Ann Cole				Date of Dea Month	eg. No. ——————————————————————————————————	3. Time of Death
a Lamin	Ĭ	4a. Facility Name (if not institution, give street and number) 141 North Broadway	14	b. City, Town, or L Baltimore	ocation of Dea	May 16, 2	4c. County (of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bir 217-56-9876 1 M 2 XF 61		If Under 1 Year Months Days		8. Date of Bi	rth(MM/DD/YYYY	9. Birthplace (State or Foreign Country) MD
w any	ĺ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location					10d. Inside City Limits
with the Maryland ms 23a nr 28a-f show be notified at once.	Director	MD N/A 10e. Street and Number		Baltim 10f. Zip Code	ore	1	0g. Citizen of Wr	1 Xes 2 No
the h		141 N. Broadway 11. Marital Status 12. Was Decedent Ever in U.S.	12 140	21231	ania Orinina (Sanife Van an Na	U.S.A	
or ite	Fune	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 2 Married Forces? 1 Yes 2 No 3 Widowed 4 X Divorced If Yes, Give Year	If Ye	s Decedent of Hisp es, specify Cuban, Yes 2 X No	Mexican, Puer		Specify:	- American Indian, Black, e, etc
2 hours	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	siness/Industry					
21215-0036 und be filed within 7 Mental Hygiene. marked nther than it event, the Medica	E S	10th Grade C77. Father's Name (First, Middle, Last)	Cour	t Clerk		ne (First, Middle,	State Maiden Surname	
121 Id be fi Mental I	8	James Matthews 19a. Informant's Name/Relationship (Type, Print) 119	h Mailing			sa Tate		n, State, Zip Code)
MD 2 shou Ith and N n 27 is numatic	-[Veronica Brown(sister)	724	E. 37th	St.,		ore, MI	21218
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Impurtant: If item 27 is injury or other traumatte		1 Burial 2 Cremation 3 Removal from State cremat 4 Denation 5 Other Specify: On-Si	tory or oth ite	Cremato	ry 5		Baltin	City or Town, State more, MD
Bal permit Depar Impu	1	21. Sig. ature of Funeral Serv. e. icen.	21	sephodes 40 N. F	ulton	n Jr. F Ave.,	uneral Baltimo	Home PA ore, MD21217
Physician /Medical Examiner		23a. Fan Enter the press, or complications that caused the dean Long failure. List only one cause on each line. Immediate Cause (Final disease a. Gastrointestinal hemorrhage		e mode of dying, s	uch as cardiac	or respiratory arr	est, shock, or hea	Approximate Interval Between Onset and Death
_Adminer	1	or condition resulting in death) Due to (or as a consequence of): b Liver Cirrhosis						
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause						
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
	g G G	d. UNPENDED AMENDED						
Division of Vital Records, P.O. Box 68760, To the Hospital ar Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic proprietely filled in by the funeral director, page 2 should be detached for use as the burnal of the proprietely filled in the funeral director, page 2 should be detached for use as the burnal of the proprietely filled in the funeral director of the proprietely filled in the funeral director.	울	IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 4 Pregnant at time of death		al death 3 [Ectopic preg	nancy	23d, Date of Month	delivery Day Year
D. Bo	Phys Syl	1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting	g in the ur	nderlying cause giv	ren in Part I.	23e. Did to	obacco use contri	bute to the cause of death?
ires that the signed by the detache	D O					1 Yes	2 No 3	Probably 4 V Unknown
Division of Vital Records, ral ar Attending Physician: The law requir is after death. al Director: After this certificate has been seled in by the funeral director, page 2 should be attended.	Completed					24a. Was autop perfor 1 ✓ Yes	sy p rm <u>ed</u> ? d	Vere autopsy findings available rior to completion of cause of eath? Yes 2 No
ician: The scertificate rector, page	8	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Out	utpatient		f Death (Chec	k only one) ing Home 5	Basidana G	Ohan Saara
lon of V tending Phys eath. tor: After thi the funeral di	tion: lo	1	Time of In	jury 28c. Injury			now injury occurre	
Division To the Hospital ar Attend within 24 hours after death. To the Runeral Director: completely filled in by the i	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, far (Specify)	arm, street	, factory, office bui	lding, etc.	28f. Location (\$ or Town, \$		er or Rural Route Number, City
To the Hos within 24 h To the Fun	ल	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.						
	Σ	29b. Signature and title of certifier		29c. License O.C.M			29d. Date signe May 17, 20	ed (Month, Day, Year) 12
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 V	V. Baltir	more Street, B	altimore, N	1D 21223		
Stat Registra	_	31. Date filed (Month, Day, Year) 22. Registrar's Signature	are	,				
HMH 17 Rev 1/200)1	OR	IGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. L Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mildred Marie Dolezar May 2012 1:35 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Nursing Home Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Director 213-22-7076 1 M 2 X F Maryland May 25, 1927 84 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, <u>the Medical Examiner must be notified at</u> Director 1 ☐ Yes 2X No Wicomico Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 USA 900 Booth Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. ş 1 Never Married 2 Married MICHER DOLLAR Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: Specify: white Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 self employed housecleaning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked o any injury or other traumatic eve once. ပ Stanley Messick Minnie Pearl Larmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert S. Hill/son 31616 Dagsboro Road Delmar, MD 21875 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Si nature of Flunera Service Licensee ²² Name and Address of Facility State Anatomy Board 655 W, Baltimore STreet Director 21201 MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ZHEIM disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death.

To the Funeral Director: After this certificate has been signompletely filled in by the funeral director, page 2 should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 1100 1 Yes ☐ Yes 2 🔽 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: ည 1 🗌 Yes 2 🕡 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Many of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) te. STORN

Registrar

State

2. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_ 1	For State Registrar	Oldio of Mic	il y laira /	Certificate of I	Death		Reg. No.				
	Physicia	n/	Decedent's Name (First, Middle, La. Henry Deshaw	st)				2. Date of De Month	ath 26 ^y	2012	3. Tinle of Death 6 08:15 AM		
->	Medic Examin		4a. Facility Name (if not institution, give	e street and number)		4b. City, Town, o	r Location of Death			nty of Death			
	Funeral Director		5. Social Security Number 6. S 012–16–7150 1	ex 7. Age 95	(In yrs. last bir	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July 24,	th				
	Maryland 28a-f show stified at	٠, ١	Usual Residence of Decedent 10a. State 10b. County Maryland Harford		10c. City, Tow						od. Inside City Limits		
:	with the 23a or 2 st be no	Funeral Director	10e. Street and Number 807 Lynn Lee Dr.			10f. Zip Code 21001			10g. Citizen d U.S.	of What Country A.	ry?		
036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The Bath and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ⊡ Married 3 🎗 Widowed 4 ☐ Divorced	12. Was Decedent Ex Armed Forces? 1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Dates.		13. Was Decedent of Hif Yes, specify Cub.		pecify Yes or No- o Rican, etc.)	14. R B Speci	ace - America lack, White, et ify: Whit	tc.		
Baltimore, Maryland 21215-0036	vithin 72 hour iene. ir than "natu the Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)			a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired, Clargy	during most of woi	rking	1	Business Indi	1		
and	be filed w ental Hyg ked othe ic event,	To Be	17. Father's Name (First, Middle, Last) George DeShaw		· · · · · · · · · · · · · · · · · · ·		18. Mother's Na Arcini	me (First, Middle, L a	Maiden Surna	me) (un	k)		
, Mary	d 2 should alth and M n 27 is mar er traumati		19a. Informant's Name/Relationship (1		19	b. Mailing Address (Street 307 Lynn Læ	and Number or Ru Dr. Aberde	en, Maryl	er, City or Town and 2100	, State, Zip Co	ode)		
more	Page 1 an nent of He ant: If iten ary or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	Removal from State	20b. Place of Cemetre Evans	of Disposition (Name of The Crematory Continer plants	ce) May _201	7 [□] 30 2	20c. Locatio Fores	n - City or Tov t Hill ,	vn, State MD		
Balti	permit. Page 1: Department of I Important: If ite any injury or of		21. Sign - ure a Funeral Service Licen	Jeffrey Te M01543	terman	22. Name and Addre	oss of Facility Eva Dr. Forest	ns Funera Hill,MD	l Chapel 21050	& Crema	tion Services		
P	nysician/		23a. Part 1 Interfue disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition	(the death. Do	Avt	ng, such as cardiac	or respiratory ar	rrest,		Approximate Interval Between Onset and Death		
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ls, P.O.	uires that the n signed by ild be detacl	þ	Part II. Other significant conditions of	contributing to death bu	it not resulting	in the underlying cause g	iven in Part I.				e cause of death?		
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Vital V	ysician; s certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ER/C	26. F Outpatient 3 DOA Oth	Place of Death (Che	eck only one) Home 5 \square Resi	idence 6 🗆 C	other (Specify)			
on of	nding Phi ath. • After thi e funeral		27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injur (Month, Day	y 28b.	Time of 28c. Injury wor	ry at	1		ow injury occurred			
Division of Vital	to the Hospital or Attending Physicians, within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	3 Suicide 6 Could not 4 Homicide determined	arm, street, factory, office			n (Street and Number or Rural Route Number, own, State)						
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	To the Comp		29b. Signature and title of certifier	aus ~	10	29c. Licens				ned (Month, D			
	(18h		30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Print)	tion st-	Harra	L De (man	MD 21078		
n	Sta Registr	te ar	31. Date filed (Month, Day, Year) NAY 3 0 2012	32. Registra	Signature	Mal		V		3			

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Medic	al	Michael Du	4b City Town o	4b. City, Town, or Location of Death					of Deatl		:15	ДM				
Examin	er	Hart Herita			201)		Street	200411011				Harford				
Funeral Director		5. Social Security No. 149–03–612	8	6. Sex 1 X M 2 □ F	7. Age (In yrs.	last birthday 92 Yrs.) If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Birtl Aug. 06,	^h Yea 7 91	19	g, Birt Cou New J	thplace (untry) C Jerse	State or Fo Liftor V	reign
nd how at		Usual Residence of 10a. State	Decedent 10b. County		10c. Ci	ty, Town or l	_ocation	-				-		10d. In:	side City L	.imits
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ath wir	uner	5 Vermont 1	Place	12. Was Dece	dent Ever in U	S. 13	3. Was Decedent of F						e - Ame	rican Ind	lian,	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Marr		If You Give	2X No e		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No			Rican, etc.)			ck, White : Whi			
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permit. Depart Import any inj once.		21. Signature Fu	neral Service	Licence Jeffre	y R. Tes (MO1	terman 543)	22. Name and Addre Evans Funera 3 Newport Di	ss of Faci	pel &	Cremetica	Serv	v <u>i</u> œs	- B	el Ai	r	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2	2 Medical	g Physician: To the b Examiner: On the bar g Nurse Practioner:	sis of examinati	on and/or inv	vestigation, in my opin	ion, death	occurred a	it the ti <mark>me, date</mark> a	and place	e, and du	ue to the	cause(s)	and mann	er stated.
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Sta	te -	31. Date filed (Mon	th, Day, Year)	32. F	Registrar's Sign	ature	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 19a, b per th g928 6-5-12 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 27 Physician/ Josephine Debutts 2012 12:45 p^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** n/a Beechdale Road Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Min 220-09-5403 Hours **Director** 1 - M 2 XF 101 Maryland Dec.26,1910 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Ħ the Maryland Director notified 1
√Y Yes 2 □ No Baltimore Maryland n/a 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be Funeral USA 21210 1 Beechdale Road ural", or items 2 I Examiner mus Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: white "natural", 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working er than the Me life. DO NOT use retired) Elementary/Secondary (0-12) 12College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the N Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Josephine Putney William Page Dame 19a Informantis Name/Balationship (Type, *Print*) Asby Thompson/daughter 19b. pailing Ardress (Street and Number or Rural Route Number, City or Town, State, Zip Code)
31 Parliment Court Baltimore, Maryland 21212 Department of Health a Important: If item 27 is any injury or other traionce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 5/29/2012 Baltimore.Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory,Inc. 22. Name and Address of Facility Cremation Society of Marylan, Inc 21. Signature of Funeral Service Licensee Stephanie Custer 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate shock, or heart failure. List only one causi Interval Between set and Death Immediate Cause (Final Pnysician/ nemmed disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the humanital completely filled in by the funeral director, page 2 should be detached for use as the humanitan that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Month Pregnant at time of death Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one examiner? Hospital Other 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending ✓ Natural 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/on investigation, across operations and due to the cause(s) and manner as stated

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 6301 N Charles Street Baltimore, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 10:26A M Jacqueline Davis 2012 _ Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 3558 Elmora 8. Date of Birth (Month, Day, Year) 3 / 2 / 1 9 4 7 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 218-44-8431 Director 1 M 2 X F 65 MD Usual Residence of Decedent 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code by Funeral 21213 USA 3558 Elmora Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 2 X No o 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 21215-0036 Black 1 Yes 2 No Specify: Specify: "natural", 3 ☐ Widowed 4 🗷 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) 12th College (1-4 or 5+) City Of Baltimore Data Entry Clerk yrs. Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Tate Samuel Mitchell, Sr. t. Page 1 and 2 should by thent of Health and Mercant: If item 27 is mark. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Todd Winkler- Son 3584 June Way Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Pk. 5/29/2012 Randallstown, MD 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee 1101 E. North Avenue Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ lung camer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year signed by the a 1 ☐ Yes 2 ☑ 9 ☐ Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Vone 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page erform death? this certificate 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital examiner' 2 🛂 No Hospital: Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) uneral Director: After the filled in by the fire 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or within 24 hours at To the Funeral D 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) D69268 who completed cause of death (Item 23a) (Type, Print) Lithery. 11, MD 21093 40. 10753 Falls Rd 717件

Registrar
DHMH 17 Rev 06-2011

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Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier Certifying Ph	nysician: To the best of m miner: On the basis of exa	y knowledg	e, death occurred a	t the time	e, date and pla	ace, and	due to the ca	use(s) a	nd manner as	stated.	4-41
the H thin 24 the F mplet	B e	only one) 3 L Certifying Nu	rse Practitioner: To the t	pest of my k	nowledge, death occ	urred at th	he time, date a	nd place	, and due to the	he cause	e(s) and manner	as stated.	tated.
5 ≥ 6 8		29b. Signature and title of certifier			290	. License	number	71.0		29d. Da	te signed (Mon	th, Day, Year)	
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4.		CHEWAUS	WARES	Po	BOP	17	37 5	XC	YB	Be	y u	D21801	
Sta Regist		31. Date filed (Month, Day, Year) MAY 3 0 2012	32. Registrar	Signature	مع					/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MALY 10:00 AM 2012 Elizabeth Ann Daly Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3274 Jones Rd Woodbine Howard If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 214-12-2563 91 Director 1 □ M 2 😿 F 12/23/1920 Maryland Usual Residence of Deceder s 23a or zoo . nust be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md Woodbine Howard 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 21797 USA 3274 Jones Rd 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Force "natural", or 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 27 is marked other than "natural traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) $\overset{\text{College (1-4 or 5+)}}{Yr}.$ Elementary/Secondary (0-12) and Mental Hygiene. is marked other tha Homemaker Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked o any injury or other traumatic evenones. ည Morgan Stewart Prentiss Mary Elizabeth Maccubbin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Floyd (Daughter) 3268 Jones Rd. Woodbine, Md. 21797. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) All County Cremation 05/30/2012 Sykesville, Md. Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chape& P.O. Box 195 Sykesville, Md 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory ar shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PAILURE Physician/ DNOESTIVE disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No should be detached for Month Year Day Pregnant at time of death the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Box 68760 P.O. Records, Division of Vital e Hospital or Attending P 24 hours after death. Funeral Director: After the To the Hospital within 24 hours a To the Funeral E

Registrar

only one 29b. Signature and title

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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May John Anderson Dougherty, Sr. 2012 4:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Lutherville 17 Croftley Road Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs.
Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours 1 🕅 M 2 🗆 F Director 165-12-0190 92 Aug. 7, Yrs 1919 Pennsylvania f show 10b. County ed other than "natural", or items 23a or 28a-f showere, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Lutherville Maryland 10e. Street and Number 10g, Citizen of What Country? Funeral 17 Croftley Road 21093 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturers Representative Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental P 2 Mabe 1 James Dougherty Anderson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a 4859 Wharff Lane Elicott City, Maryland Son John A. Dougherty, Jr. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Durkmarker yretyten) bretyer place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. injury or 5-31-2012 Maryland Memorial Gardens Timonium ☐ Donation 5 ☐ Other (Specify) Ruck Towson Funeral Home, Towson, Maryland 21204 22. Name and Address of Facility 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only or Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician a d be detached for use as the burial-Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) _____ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy nerformed 1 Yes Yes the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 146 ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Watural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title q 29c. License number 29d. Date signed (Month, Day, Year, MD 71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUITE KUMAR 701 N CHARL ST Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar /Medical

Medical Certification: To Be Completed by Physician/Medical Examiner

29b. Signature and title of pertifier

31. Date filed (Month, Day,

Year)

MAY 30

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

For	State of Ma	aryland / Dep	artment o	of Health a	and Me	ental Hygi	ene			
State Registrar		Ce	ertificate	of Death		Re	g. No. 2 () 12	2 167	18
Decedent's Name (First, Middle, La	ist)					2. Date of Death Month	Day	Year	3. Time of De	eath
Wathan Da	niels					5-26		07	2 1:20	MC
. Facility Name (If not institution, give			4b. City, To	own, or Location of	of Death		4c. County		h	
LEVINDALE HEBRE		- (la vera land bidhata		LTIMORE Year If Under	24 Hrs. T	8. Date of Birth]	V/A	h-la (Ot-ta)	
	Sex 7.Age 1.2XM 2F	e (In yrs. last birthda) Yrs.		Days Hours	Min.	(Month, Day,			hplace (State or F untry)	-oreign
ual Residence of Decedent		91 113.				04/24/1	921		NY_	
a. State 10b. County		10c. City, Town or I	Location						10d. Inside City	Limits
MD N/A		BALT	IMORE						1 [X]Yes 2	□ No
e. Street and Number			10f. Zip Co	ode		10	g. Citizen of	What Co	untry?	
6807 PARK HEIGH	TS AVENUE,	APT. 2E		21215			US	SA		
Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13	. Was Deceder If Yes, specify	nt of Hispanic Ori y Cuban, Mexicar	gin? (Spec	cify Yes or No- tican, etc.)		ce - Ame	rican Indian, e, etc.	
1 Never Married 2 Married	1 XYes 2 □ N If Yes, Give		1□Yes 2□				Specia			
3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	10. 8		0					WHITE	
15. Decedent's E (Specify only highest gr	ducation ade completed)	ı (Giv	cedent's Usual (ve kind of work of . DO NOT use of	done during mos	t of working		6b. Kind of E	usiness/	inaustry	
Elementary/Secondary (0-12)	College (1-4or 5	5+)	SALESMA	,			CLOTI	HING		
Father's Name (First, Middle, Las	t)			18. Mothe	er's Name	(First, Middle, M	aiden Surna	me)		
PAUL	1	DANIELS		CEL	ΙA		_		SOLOMON	
a. Informant's Name/Relationship	(Type. Print)	19b. Ma	iling Address (S	Street and Numbe	er or Rural	Route Number,	City or Town	, State, Z	Zip Code)	
MINNIE DANIELS/	WIFE						BALT	[MOR]	E, MD 21	215
a. Method of Disposition		20b. Place of Disp	position (Name	of :			On Lanation	Oik. as	T 0: 1	
	Removal from State	cemetery, ci	rematory or othe	er place)	Da	ate 2	oc. Location	- City or	Town, State	
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State Registrar

DHMH 17 Rev 1/2001

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D0056414

MD, MPH

-Sayed 2434

and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mark 28 20 1º2 James Rodney Dize, Sr. 5:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 940 Hughes Shop Rd. Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Dec. 10,1932 Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Min 1 🛛 M 2 🗆 F Country) Maryland **Director** 219-28-8542 79 Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Carroll 1 Yes 2 No Maryland Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 940 Hughes Shop Rd. 21158 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 0 1 Never Married 2 Married þ ☐ Yes 2 XNo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: White 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Teamster's Local 557 Secretary Treasurer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Clifford Collins Dize Catherine Maddox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia Glendenning / Daughter 1020 Huntfield Rd. Westminster, MD 21157 20a. Method of Disposition Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite Meadowridge Meadowridge Memorial Park ò XXBurial 2 Cremation 3 Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) June 1,2012 Elkridge, MD Signature of Juneral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel Celar 11605 Reisterstown Rd. Owings Mills, MD2111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events burial-transi and Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months? Ectopic pregnancy Day Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 No Yes 2 No 1 Yes Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital: Other: 2 **N**0 1 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗙 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 Yes 2 No M Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined building, etc. (Specify) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marker as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) a 7 Name and address of person who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene 2 0 1 2

			For State of Man		artment of F			ene 2012 g. No.	2 16790		
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Margaret E. Ellers				2. Date of Death Month May	28, 2012	3. Time of Death 10:15A M		
	Examir		4a. Facility Name (if not institution, give street and number) 23 A Delrey Avenue		Catons		.,	4c. County of Deat Baltin	h Nore		
	Funeral Director	ř	214-20-5730 Usual Residence of Decedent	86 Yrs. Dc. City, Town or Lo	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) Co.	thplace (State or Foreign untry) Tryland 10d. Inside City Limits		
	the Marylar or 28a-f sh oe notified	Director	Maryland Baltimore 10e. Street and Number	-	Catonsvil	le	10	1 ☐ Yes 2 🌠 No			
036	ge 1 and 2 should be filed within 72 hours after death with the Maryland to 6 Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	23 A Delrey Avenue 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	in U.S. 13. \	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: White			
Baltimore, Maryland 21215-0036	within 72 hour giene. er than "natu er the Medical"; the Medical	e Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1	(Give life. D	dent's Usual Occupa kind of work done o O NOT use retired) Homemaker	ation during most of worl	king 1	6b. Kind of Business/			
ryland	should be filed and Mental Hy, rand Mental Hy, ris marked oth raumatic event.	To Be	17. Father's Name (First, Middle, Last) Frederick William Heinicken	T		Ethe:	ne (First, Middle, Ma l Leta Le	nox			
re, Ma	1 and 2 sho of Health and item 27 is 1 other traur			nd 23 A	Delrey A	venue Ca	tonsville	ity or Town, State, Zip , Maryland Oc. Location - City or	1 21228		
3altimo	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee George E.	Woodlawn	natory or other place Cemetery 2. Name and Address MacNabb	06/	02/12 W Home, P.	oodlawn, N	Maryland 0 21228		
60 by .	be executed Wedical Examiner The burial-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cause). Due to (or as a condition of the cause).		ARCANC		Approximate Interval Between Onset and Death				
Box 687	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of particle of the past 12 months? 4 ☐ Pregnant at times of the particle of th	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	23d. Date of delivery Month Day Year		
rds, P.O.	requires that the been signed by should be deta	by	Part II. Other significant conditions contributing to death but r	not resulting in the u	underlying cause giv	ven in Part I.	1 🗌 Yes	the cause of death?			
I Reco	ysician: The law n is certificate has b director, page 2 sh	e Completed	25. Was case referred to medical		26. Pk	ace of Death (Chec	24a. Was an autopsy perform 1 Yes 2	prior to death?	topsy findings available completion of cause of		
of Vita	ding Physicie h. After this cerl funeral direct	te: To Be	27. Manner of Death 28a. Date of injury	2 ER/Outpatier 28b. Time of injury	nt 3 🗆 DOA Othe	er: 4 Nursing H	. /	ce 6 Other (Specinjury occurred	ify)		
Division of Vital Records,	To the Hospital or Attending Physician: To thin 24 hours after death as the Funeral Director After this certific completely filled in by the funeral director,	Certificate:	1 Actival 5 Pending (Month, Day, Ye) 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of injury building, etc. (S	- At home, farm, str	M 1 □	Yes 2 □ No	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,		
_	the Hospit thin 24 hour the Funera mpletely fills	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examonly one) 3 Certifying Nurse Practitioner: To the best of my 2 Medical Examiner: On the basis of examonly one)	nination and/or inves	tigation, in my opinic , death occurred at t	on, death occurred a he time, date and p	at the time, date and lace, and due to the	place, and due to the cause(s) and manner a	cause(s) and manner stated. is stated.		
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		29b. Signature and the of certifier (M)	h (lhom 00-)		6354		d. Date signed (Mgnt) $\frac{30}{2}$	012		
		· 0 -	30. Name and address of person who completed cause of death COLE 900 CA 70 31. Date filed (Month, Pay, Year) 32. Registrar's	Signature	STAG	FNES	BALTIA	MURE MI	021229		
	Sta Registr	ar	31. Date filed (Month, Day, Year) 32. Registrar's	sarke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2013 14ARLES EVAMS 2357 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City_Town, or Location of Death 4c. County of Death BALTIMORE BALTIMORE COUNTY HOSATAN VORTHUEST If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** March 5 Months Hours Min 1 X M 2 🗆 F 74 T938 Maryland Director 217-34-7387 Usual Residence of Decedent 28a-f show 10b. County items 23a or 28a-f sho her must be notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🕅 No Maryland | Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10105 Marriottsville Road 21133 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. 0 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Divorced Specify: White Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Steel Worker Bethleham Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Ith and Mental F 27 is marked or r traumatic ever permit. Page 1 and 2 should be Department of Health and Menta Important. If item 27 is marked any injury or act. ည Donald Evans Emigene Rearick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LiLi Evans / wife 10105 Marriottsville Rd.Randallstown, MD. 21133 altimore, 20a. Method of Disposition
1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Metro Crematory, Inc. 5/24/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facilit Cremation Society of Maryland, Inc ture of Funeral Service PicenseeStephanie Custer 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death CARDIAC ARRYTHMIA Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last physician and s the burial-tran burial-trar Due to (or as a consequence of): Physician/Medical Box 68760 attending IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: The law requires that the death for Month Day Year Pregnant at time of death signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **₽** MYELOMA Division of Vital Records, 1 Yes 2 10 3 Probably 4 Unknown Completed phould peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed's certificate 2 **N**O 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 \square No ျှ 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpa this funeral (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Director: After Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Investigation filled in by the Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier 📂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title

13

Registrar

31. Date filed (Month, Day, Year

1447 YORK ROAD SWITE LOD

TOWSON

MANYLAND

21097

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last UWARD Physician/ EDWARDS Medical 4a. Facility Name (if not institution, give street and number, 4c.County of Death Baltimore Co 4b. City, Town, or Location of Death **Examiner** Windsor Mill Northwest Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 218-31-6058 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 1 X M 2 - F 03/18/1991 Maryland 21 or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director Elkridge 1 Yes 2 XNo Howard Co. MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a o Examiner must be Funeral U.S.A. 21075 Amberton Dr. 6600 E. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black. White, etc Completed by 1 X Never Married 2 Married 1 ☐ Yes 2 ☐xNo If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. College (1-4 or 5+) T2th Grade (0-12) N/A Disable Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, n and Mental I မ Renee Williams Jimmy EdwaRD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1219 E. Chase Street, Baltimore, MD 21202 Sherry Williams(sister) of Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. 1 Burial 2 Tremation 3 Removal from State on-site Crematory 05/25/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic ²²Josephden fra Frown Jr. 2140 N. Fulton Ave., Funeral Home PA Baltimore, MD 21217 Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ neumon disease or condition Medical resulting in death) as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as the burial-transit or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No should be detached for Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown the been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s after death.

Director: After this certificate I 2 No Yes 25. Was case referred to edical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Could not be Accident 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier

State Registrar

3

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 Day Month 20T2 6:40 РМ Walter William Faulkner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Timonium Baltimore Stella Maris Inc. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** April 9, 1928 Days Hours Min Maryland Director 216-20-6095 84 Usual Residence of Deceder permit. Page 1 end 2 should be filed within 72 hours after death with the Meryland Department of Heelth end Mental Hygiene. Importent: If Item 27 is marked other than "nature!", or items 23a or 28a-f shov any injury or other treumatic event, the Medical Examiner must be natified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 x No Harford MD Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 103 Waldon Road #K 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4_or 5+) laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Nelson Faulkner Virginia Irma Floyd 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2205 S. Southern Rd; Middle River, MD 21220 Joseph Faulkner - brother 2012 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🗓 Other (Specify) in state Signature of Funeral Service Licerisee Nache, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysiciani CANCER UNKNOWN PRIMARY Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir ettending physician and I for use as the burlel-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery WALTER FAULKNER 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year sate has been signed by the e page 2 should be detached i 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an burs efter death. erei Director: After this certificate has I filled in by the funeral director, page 23 autopsy Yes 2 X N 2 🗌 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **HOSPICE** 1 ☐ Yes 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours e To the Funerei D completely filled Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MORGAN, CRNP 2300 TIMONIUM, MD 21093 TRACIE L. DULANEY VALLEY RD. 31. Date filed (Month, Day, Year) Registrar's Signa State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 11201 thines 2 Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) Age (In vrs. last birthday) Funeral Months Hours 207-26-1813 1 **X** M 2 □ F Director Sept 26, 1934 Pennsylvania 77 show 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2X No Pikesville MT Baltimore 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21208 USA 7 Sudbrook Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify. white **'**56**-**58 3 Widowed 4 Divorced Year or Dates. event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. 5+ guidance counselor education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Miles Reisner Fasnacht Helen Marica Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. JoAnn Fasnacht/spouse 3730 Eastman Road Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board Baltimore, MD 2120 Ronal d 655 W. Baltimore Street Baltimore, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or deart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock Immediate Cause (Final Physician/ 2 disease or condition resulting in death) Medical a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician s the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? ģ Year Month Day Pregnant at time of death 1 Yes 2 9 Unknown ed by the a detached f 9 Unknown signed by to ld be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Inknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed Yes 2 N No 1 🗌 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 this Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 29b. Signature and title 053850 cause of death (Item 23a) (Type, Print) IRR State

Registrar

12-03935 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Tavon Frederick 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 23, 2012 CAPRICE 2054 hrs **Medical Examiner** AVON 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore 3312 Westerwald Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director Country) 215-90-9964 1 📈 M 2___F 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No es 23a or 28a-f show e notified at once. MD BALTIMORE Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number ENUE Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 Never Married Yes 2 X No Specify: BLACK If Yes, Give Year 1 Yes 2 No specify: 3 Widowed 4 Divorced ۾ 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) nt of Health and Mental Hygiene.

tt: If item 27 is marked other than "
other traumatic event, the Medical] ONSTRUCTION DRY WALLER 18.Mother's Name (First, Middle, Maider 17._Father's Name (First, Middle, Last) FREDERIC 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOTHER AVE. BAUTO, MD. 21218 NESTERWARD HEEDERICK Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State BATIMORE, MD KING MEMORIAL Donation 5 Other Specify GREENE FUNERAL SCYS BAUTO OAO 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transi Physician/Medical UNPENDED AMENDED 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. é 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed death? ✓ Yes 2 No 2 No page 1 🗸 Yes 26.Place of Death (Check only one) 25 Was case referred to medical of Vital Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other Scene ER/Outpatient 3 DDA this 1 V Yes 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification Subject shot May 23, 2012 1 Natural 1 Yes 2 ✔ No Pending the Investigation Accident filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) 3312 Westerwald Avenue, Baltimore, MD within 24 hours at To the Funeral I determined (Specify) Single Family Home 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) May 24, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD. Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

COLAR

32. Registrar's Signature

31. Date filed (Month, Day Year) ---

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:39 A M Mayonth 26 Day 2012 Year Frank Anthony Faraino Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 0ak Tree Court Timonium If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min Jan 23, 1 X M 2 🗆 F Months **216-12-**9773 90 1922 Marviand **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Maryland Timonium 1 Tes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A. 21093 23 Court Oak Tree within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian, Armed Forces
1 X Yes 2 If Yes, Give
Year or Dates. Black. White, etc 1 Never Married 2 Married þ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 K Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that any injury or other traumatic event, the Mental injury or other traumatic event. College (1-4 or 5+) Medeicine Medical Doctor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Mary Muffoletto Faraino Antonio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Faraino McCarthy/Daughter 11857 Sherbourne Dr. Timonium, Md. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 5/30/2012 DulaneyValleyMemGdn Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Source Line 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ken disease or condition Medical resulting in death) Due to (or as a con. uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death signed by the al d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 🗌 No Yes 2 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 Tes 2 📈 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending s after death. 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of pertifier 29c. License number

Registrar

State

30. Name in

DHMH 17 Rev 7/2009

Such 4105 Baltimore

address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#20a-c, 22perFH, 6928,6/14/2012 WS State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 17, 2012 1:11 PM M Kevin Green . Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days Min. Months Hours (Month, Day, Year) Director 442-68-1135 1 X M 2 - F 49 1963 0klahoma ral", or items 23a or 28a-f shov Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b County 10c. City, Town or Location 10d. Inside Cify Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA 3619 Manchester Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black White etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🏋 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: black 3 ☐ Widowed 4 🎇 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) alth and Mental Hygiene.
27 Is marked other than r traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 disabled none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ဂ္ Clarence Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Green/daughter 12353 Beamer Road #812 Houston, TX 20a. Method of Disposition
1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 5 Important: If any Injury or 4 ☐ Donation 5 ☐ Cther (Specify) in state 6-1-2012 Atlantic Crem. Glen_Burnie, MD 22 Name and Address of Facility Simplicity Cremation and Funeral State Anatomy Board Shows Part Invite Street Signature a Funeral Service Lifensee Way Ridge Rd Hanover, MD <u>21201</u> 7090 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) dusdenum Physician/ ancer MERRY Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Director: After this certificate has been signed by the a d in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the of certifie 29c. License number 5830 MA4 17 2012 address of person who completed cause of death (Item 23a) (Type, Print) TOW NO MO N-Charles AMON 670 31. Date filed (Month, Day, Year)

MAY 3 0 2. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 17 2012 5:24 PM Warren J. Gore Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. Days Director 218-26-5349 1 XM 2 □ F 84 Feb 10, 1928 Maryland oortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director MD Baltimore 1 ☐ Yes 2X No Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 310 overlook Drive 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 X Married X Yes Yes, Give Completed by Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk unk 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John William Gore Emma Marie Knoch Department of Health and Important: If item 27 is m. any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn Gore/spouse 310 Overlook Drive Timonium, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Ronald S. Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examin The law requires that the death certificate be executed and burial-1 physician s the buria Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery atten I for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical $\mathbf{B}_{\mathbf{e}}$ 26. Place of Death (Check only one) Hospital: 2 No 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pending iniury Accident Suicide Investigation Funeral Director: / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical within 24 hou

To the Funer

completely fi 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D0060406 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician 26 20:05PM 2012 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Medical Center Baltimore 9. Birthplace (State or Foreign Country) Baltimore Maryland If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 63 July 13, 1948 220-52-6426 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 1 ☐ Yes 2 🔀 No Director Maryland Harford Forest Hill the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code Pages 1 and 2 should be filed within 72 hours after death with 3409 Baywood Drive U.S.A. 21050 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white þ 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Owner - Five Star Wholesale Pet Wholesale/Distribution 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ith and Mental F 27 is marked of traumatic ever Kurt J. Gran Agnes L. Burtis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important; If item 27 is any Injury or other trau 3409 Baywood Drive, Forest Hill, Maryland 21050 Mrs. JoAnn Gran (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date June 01, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fallston, Maryland 2012 Highview Memorial Cardens Pe of Funeral Service Licenses Jeffrey R. Testerman 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Bel Air (M01543) | 3 Newport Drive, Forest Hill, Maryland 21050 | Approximate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval or beart failure. List only one cause on each line. 21. Signature Approximate Interval Between Onset and Death PNEUMONI Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions. Examiner sequentally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical iding use a IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 2 X No 1 Tyes certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? 1 ☐ Yes 2 🗹 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA မှ this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 Natural 1 🗌 Yes 2 🗌 No death. 2 Accident Director: A 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide City or Town, State) after within 24 hours aff

To the Funeral Di

completely filled in 1 Kcritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

11595

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ANUREAS S. BARTH

31. Date filed (Month, Day, Year)

RES-000

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 23. Time of Geals 0 2:05 PM Physician/ Louise Goldbaum May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Chevy Chase 3603 Dundee Drive Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days (Month, Day, Year) **Director** 113-12-5036
Usual Residence of Decedent 1 □ M 2**X** F 92 Jan 25, 1920 New York 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 X No MD Montgomery Chevy Chase o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3603 Dundee Drive 20815 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ᆼ þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 self employed store owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry Gutwill Sarah Shultz traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Judith Blanchard/daughter 3603 Dundee Drive Chevy Chase, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 X Donation 5 ☐ Other (Specify) Ronald S. W 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Ronald Director Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): and burial-tran resulting in death) Last Due to (or as a consequence of) physician Hospital or Attending Physician: The law requires that the death certificate be each hours after death.
 Funeral Director: After this certificate has been signed by the attending physicia. Physician/Medical Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy for 5 Other (specify) Month Pregnant at time of death Day Year signed by the all 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has ral director, page 2 autopsy performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 \sum Yes Hospita မ 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation М Suicide 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check To the I within 2 To the I 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18 34032 12 address of person who completed cause of death (Item 23a) (Type, Print) FARRAGUT AVE, KENSIN BANNE M.D., 3720 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician 8:15am /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Baltimore County Ivv Hall Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday 5. Social Security Number 6 Sex **Funeral** Months 1 □ M 2 □ F October 25 1925 Pennsylvania 86 199 14 9843 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c, City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Baltimore County Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21220 705 Compass Road Apt 425 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes Give 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify. Specify. If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 White þ 3X Widowed 4 ☐ Divorced 16h Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Housekeeping-Own Home ΝΆ Housewife 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ceceil Williams William Haywald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lakeland, Florida 33805 3206 Railway Avenue (Brother) Richard Haywald 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Baltimore, Maryland Metro Crematory Inc. May 24 2012 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} Lassahn Funeral Home Inc 7401 Belair Rd Baltimore, Maryland 21236 21. Signajure of Funeral Service Licensee 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causi on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner The law requires that the death certificate be executed burial-tran ie to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23d. Date of delivery If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a detached f 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Whiknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed , page 2 1 Yes certificate or Attending Physician: 25. Was case referred t ...edical examiner? 26. Place of Death (Check only one) funeral director, Other: Hospital: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 3□ DOA 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient Medical Certification: To After this 28d. Describe how injury occurred 27. Manner death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury 5 Pending investigation 1 tural 1 □ Yes 2 □ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of

State Registrar

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Maryland 2	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) Roosevelt Grah	am		_		ame (First, Middle n Eaddy	, Maider	Surname)			
			19a. Informant's Name/Relationship (7) Angie Sharpe-D								nore, Md		
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 4 Onnation 5 Other (Special	Removal from State 20b. P	lace of Dispos	sition (Name of natory or other pla	ace)	Date 30/2012	20c. l	_ocation - City or	Town, State		
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	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director. After thi completely filled in by the funeral	Medical	(Check 2 Medical Exam only one) 3 Certifying Nur	sician: To the best of my knowl iner: On the basis of examination se Practitioner: To the best of n	and/or invest	igation, in my opin death occurred at	nion, death occurre the time, date and	ed at the time, date	and place the caus	e, and due to the se(s) and manner	cause(s) and manner stated. as stated.		
	5 8 8 8		29b. Signature and title of certifier	ull mp		29c. Licens			V		1 2012		
(30. Name and address of person who		23a) (Type, P		PITALO	PBALT		-	BELVEDELL HLTPMORE MD 212		
	Sta Registra		NAY 3 0 2012	32. Registrar's Signat									

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 1018 PM DELOIS **EPPS GREEN** Medical Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** throw Homore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 KF Funeral Months Davs Hours Min. APRIL D3 VA 79 **Director** 212-34-3512 Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director MD ANNE ARUNDEL PASADENA 1 X Yes 2 No 10e. Street and Number 10f, Zip Code ö 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a Funeral 21122 IISA 375 ARGYLE AVE. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced ack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) BENEFIT EARNINGS TECH SOCIAL SECURITY ADMIN be filed v Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)

ANNIE EPPS ပ **GEORGE PRYOR** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra HOWARD D. GREEN/ HUSBAND 375 ARGYLE AVE. PASADENA, MD 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State
 Donation 5 ☐ Other (Specify) 06/01/2012 | BALTIMORE, MD KING MEM. PARK 21. Signature of Funeral Service License 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1/01-31 LAURENS ST. BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Immediate Cause (Final Physician/ 24 disease or condition Medical resulting in death) Due to (o s a consequence of): **Examiner** q cu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. been signed by the a ending physician and should be detached for use as the burial-transit Due to (a) as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 □ Fetal death 3 □ Ectopic pregn*a*ncy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: 1 Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 — Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dorothy Fern Goheen May 25, 6:50 P Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oakcrest Village Care Center Baltimore Baltimore . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours **Director** 227-12-2485 1 ☐ M 2🔀 F Oct. 8, 1916 95 Pennsylvania 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 8810 Walther Blvd. USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1X Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify. Completed 3 -Widowed 4 Divorced White Year or Dates 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Wilson Greenberger Martha E. Latch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, item 27 i John W. Goheen / Son 1808 Falstaff Ct., Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of H Important: If ite any injury or ott 20c. Location - City or Town, State Burial 2 Cremation 3 Report Reports Report Security Rose Hill Svcs, LLC | 5-31-2012 Bel Air, Maryland permit. 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Sid ture of Funeral 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ्री sase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Complications 2° Lhumerus and pelvic fracture after for Immediate Cause (Final disease or condition resulting in death) nset and Death Physician/ Medical **Examiner** Sequentially liet conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
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1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant : 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying 23e. Did tobacco use contribute to the cause of death? ardiomiopathi 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Director: After this certificate has performed 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completely filled it by the funeral director, it 25. Was case referred to medical examiner? or Attending Physician: Be 26. Place of Death (Check only one) မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred fell In parking lot 1 Natural
2 Accident
3 Suicide injury 5 Pending work? 1 ☐ Yes 2 No Investigation Unknown M 6 Could not be 28f. Location (Street and Number or Rural Route Number, determined side Walman Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year)

15 gr

Registrar
DHMH 17 Rev 06-2011

Walther Blud, Parkville MD 21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29^{Day} May Month Physician/ Leonard **Emanuel** Goodman 2012 4:50 A M Medical 4c. County of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cockeysville Broadmead 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Numbe 8. Date of Birth 7. Age (In yrs. last birthday) Funeral 1**X** M 2 □ F March Par 1936 Mary and 216-34-2837 76 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State Director ms 23a or 28a-f s must be notified 1 ☐ Yes 2X No Cockeysville Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21030 items 23a Funeral 13801 York Road Apt. A3 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc , or 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify. Yes. Give "natural", 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Insurance Broker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) A. Leonard Goodman Elaine Loeb Goodman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13801 York Road, Cockeysville, Maryland Saralee Goodman / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State HilltopServiceCorp. Towson, Maryland 5/30/2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 21. Signature of Funeral Serio Lucius 21204 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events quentially list conditions, Due to (or as a consequence of) attending physician and for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Medical SOUTH LEONAR Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery Physician/ 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the scompleted filled in by the funeral director, page 2 should be detached. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 ➡ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 1 24 hours after death. Funeral Director: After this certificate has b autopsy 1 Yes 2 No 26. Place of Death Check only one 25. Was case referred to Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မြ 27, Manne Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury Matural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 D'Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ²012 Physician/ Daniel S. GREEN May 26, 2:27 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4601 N. Park Avenue #92 Montgomery Chevy Chase 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In vrs. last birthday) 1 M 2 - F Days Hours Min. May 289 Ye 17916 New York 103-05-0120 95 **Director** Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No Mary land Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4601 N. Park Avenue #921 20815 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 X Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: white 3 Divorced Completed Year or Dates. WW 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Pharmacist Pharmacy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bertha Meister Elias Max Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pembroke Court, Marlboro, NJ Amy Zimbalist, Daughter 20a. Method of Disposition
1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Other (Specify) 4 Donation 5 D Montefiore Cemetery 05/29/12 St. Albans, NY of Fineral Service Lig Franky Hebrew Funeral Home M01008 254 Carroll St., NW. Washington. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myocardial Infarction Provician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Critical Aortic Valve Stenosis Sequentially list conditions Examine Due to (or as a consequence oi). if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-transit Coronary Artery Disease Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year the 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? 1 ☐ Yes 2 🗓 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Hospital 2 📉 No မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a To the Funeral D Medical 1 🛴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/of investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/of investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signat re and title of certifie 29d. Date signed (Month, Day, Year) 29c, License number 63285 MD May 27, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Ave., #515, Chevy Chase, MD 20815 Eva Hausner, M.D.,

DHMH 17 Rev 7/2009

Registra

31. Date filed (Month, Day, Year)

amend #1,per phy,g927 5-30-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) AkA Chickie Greenberg 2. Date of Death 3. Time of Death Physician/ THARLOT 33CDM GREE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 220-14-1798 Director 1 🗆 M 2 🗓 F 86 07/13/1925 MD 28a-f show 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE BALTIMORE ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1500 BEDFORD AVENUE, #512 21208 USA items ; death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Armed Forces?
1 ☐ Yes 2 ⚠ No or I' Black, White, etc. Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", Specify: 3 Widowed 4 Divorced WHITE Year or Dates Health and Mental Hygiene. tem 27 is marked other than "natur ther traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ GENE ASKIN MINNIE COHEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other to once, CHERYL KAMMERMAN/DAUGHTER POPLAR COURT, OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM 05/29/2012 REISTERSTOWN, MD 22. Name and Address of Facility Signature of Juneral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. -diOUASCULAR Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Dua to for sels correccione of If any, leading to immedicause. Enter Underlying Cause (Disease or injury Exami the Hospital or Attending Physician. The law requires that the death certificate be executed and burial-tra that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical P.O. Box 68760 as 1 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) the attending IF FEMALE asn 23b. Was decedent pregnant 23d. Date of delivery for (in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year detached 1 ☐ Yes ≥ L 9 ☐ Unknown Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performed? Yes 2 No death? this certificate Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No 읻 1 Inpatient 2 ER/Outpatient 3 DQA 4 Nursing Home 5 Residence 6 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Director, After 1 Natural work? 1 Yes 2 No 5 Pending Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one DIS872 May 25 2012 VIA TION BLUD GLEN BURNIE 106 Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6.29PM David Luke Hopkins, Jr. 23, 2012 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Broadmead Cockeysville 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours 216-24-3672 1 🛛 M 2 🗆 F 84 **Director** Maryland May 7, 1928 Usual Residence of Decede or 28a-f show 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland Cockeysville 1 Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with the of Health and Mental Hygiene.

The action 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be, other traumatic event, the Medical Examiner must be. Funeral 21030 United States of America 13801 York Road 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Black, White, etc by 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Brown Advisory Elementary/Secondary (0-12) College (1-4 or 5+) CEO Investment Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Katherine Disston Porter D. Luke Hopkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2040 Geist Road, Reisterstown, Maryland 21136 Robert D. Hopkins - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or conce. ţ 1 🖔 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place Forest Hill Cemetery July 6, 2012 4 ☐ Donation 5 ☐ Other (Specify) Northeast Harbor, ME 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 16924 York Road, Monkton, Maryland 21111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician CONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Due to (or as a consequence of) resulting in death) Last physician Physician/Medical the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ detached for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No Unknown 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use combute to the cause of death? þ þ KIDNEY CHRONIC 2 ☑No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed been s DEMENT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform after death.

Director: After this certificate Yes 2 🗌 No Yes 25. Was case referred to edical funeral director, Be 26. Place of Death Check only one) examiner? 1 🗆 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 27. Mann of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural work? 1 \(\text{Yes} 5 Pending 2 🗌 No ☐ Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) dexermined within 24 hours a To the Funeral I completely filled Hospital Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death Physician/ 0:35AM Medical give street and number) Location of Death 4c. County of Death **Examiner** 9 more 8. Date of Birth (Month, Day, last birthday) 9. Birthplace (State or Foreign **Funeral** Months **Director** 05-06-194 Usual Residence iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No n m α 10g. Citizen of What Country? 10e. Street and Numb 10f. Zip Code Funeral 229 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Hite. DO NOT us letired) 15. Decedent's Education 16b. Kind of Business/Industry ify only highest grade completed, and Mental Hygiene. College (1-4 or 5+) Be ပ Har permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau Jephei Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Situature of Fune a Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3 Approximate Interval Between Onset and Death Immediate Cause (Final Concer Pancred Physician/ disease or condition Medical resulting in death) Examiner Q 1035. Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate use as the burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy cate has been signed by the atterpage 2 should be detached for in the past 12 months? Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy within 24 hours af er death. To the Funeral Director: After this certificate 1 Yes 2 filled in by the funeral director, 25. Was case referred to managed 26. Place of Death (Check only one) Certificate: To Be examiner? 404pice Other: 4 Nursing Home 5 Residence 2 🔼 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending hin 24 hours af er death. 1 Natural 5 Pending work?
1 Yes 2 No Mildred 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10003 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID TWO 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 26 2012 Billy D 4:50 AM Hauserman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours December 25 1929 Zanesville, Ohio Director 051 24 1743 1 🗀 M 2 🗆 F 82 Usual Residence of Decedent or 28a-f show 10b. Count 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director 1 ☐ Yes 2 🏝 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10o. Citizen of What Country? 23a Funeral USA 21204 8101 Bellona Avenue items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. Specify White Completed 3 Widowed 4xx Divorced Year or Dates. Korea Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Health and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) traumatic event, the Towson University Professor of Education 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Page 1 and 2 should be **Ruth Brokow** William Edward Hauserman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9529 Longview Drive Ellicott City, Maryland 21042 John Hauserman (Son) Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State □ Burial 2 XCremation 3 □ Removal from State 29 2012 Baltimore Maryland Metro Crematory Inc. May 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licensee 22 Name and Address of Facility one Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Mec Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence or) If any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Por in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown signed by the ar 1 Yes 2 L 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown ALZHELMERS DEMENTIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: has autopsy performed? 1 Tyes 2 No Yes 2 N To the Hospital or Attending Physician: 25. Was case referred to medical director, æ 26. Place of Death (Check only one) examiner? Other: Hospic 2 No မ 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending ☐ Natural I hours after death.

Uneral Director: Aftely filled in by the fur Accident 1 Yes 2 No Fell from Seated Investigation MAY 20, 2012 1.00 PH Portion Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a RDEN ASSESTED LEVENA FACELETY COURTS TOWSON, HD Medical RELLONA AVE 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of certifier 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D71040 12 17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SULTE WIOT

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31. Date filed (Month, Day; Year) ₩

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Registrar DHMH 17 Rev 06-2011 ST

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N CHARLES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ ARPNCE Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4c. County of Death
Baltimore Seasons Hopsice Randallstown If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 244-90-0153 **Director** 1**X** M 2 □ F 59 6-3-1952 M. Usual Residence of De 28a-f show with the Maryland 10b. Count 10c. City, Town or Location be notified at Funeral Director 10d. Inside City Limits Baltimore 1 Yes 2 X No Edgemere 0 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 2525 Sycamore Avenue 21219 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 YNo If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 N Divorced Specify: African-American Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) ondary (0-12) 12th Steel Worker Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည James E. Hollins Marrie McNeill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Hollins / Former Wife 3C11 Fallstaff Manor Ct. # H, Baltimore, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ pther (Specify) King Memorial Park 6-2-2012 Woodlawn, MD 21. Signature of Funeral Son 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 200 Liberty Rd., Randallstown, MD 21133 Part 1. Enter th disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one nterval Between MALIGNAN HARYNGEAL Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery for in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed been 24a. Was an 24b. Were autopsy findings available or Attending Physician: The law To the Funeral Director: After this certificate has autopsy prior to completion of cause of death? perform 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner's 1 - Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manual of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after City or Town, State) the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature d title of certifie 29d. Date signed (Month, Day, Year) 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 4

Registrar

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Division of Vital Records, P.O. Box 687	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Certificate: To Be Completed by Physician/Medical	If any, leading to immer cause. Enter Underlying Cause (Disease or linjut that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregin the past 12 mon 1	gnant ths? o nt conditions of o medical o livestigation Could not be determined the conditions of person who of person who	Due to (or as d	e of pregna 2 Feta at time of combut not residue. Specify, of my knowlexamination e best of my death (Item 3 3 Mil.)	ER/Outpatier 28b. Time of injury ome, farm, str.) ledge, death an and/or invess y knowledge, of 23a) (Type, F	Ectopic pregnan Other (specify) Inderlying cause given the specific pregnan Other (specify) 26. Point 3 DOA Other 28c. Injury M 1 Doal Deet, factory, office Decurred at the time tigation, in my opin death occurred at the time 1 29c. Licens	lace of Death (Checker: 4 Nursing Hry at Arry 2 No 9, date and place, a noin, death occurred and place and place are time, date and place are time, date and place are time.	23e. Did to 1 24a. Was autop performed to perform 28d. Describe had been at the time, date at the time	23d. Date of d Month obacco use contribute to the second	elivery Day Year o the cause of death Probably 4 Ink utopsy findings avail completion of cause es 2 No cify) ural Route Number, tated. e cause(s) and manner s stated.	lable e of			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Esther Hendrix 6:40 AM 2012 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Potomac Valley Nursing Center Montgomery Rockville 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) **Director** 314-36-8083 1 M 2 XF 100 Indiana Nov. 29, 1911 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits the Maryland Director 1 X Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1235 Potomac Valley Road 20850 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Medical Examiner Armed Forces? Black, White, etc. ō 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify Specify: White "natural", 3 ★ Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 hand Mental Hygiene.
7 is marked other than "r life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) the Professor 5+ Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (Unknown) Lucas (Unknown) ge 1 and 2 should be nt of Health and Mer : If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27722 Tambora Drive Canyon Country, CA Chris Largent - Son 91351 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or injury or Oak Hill Cemetery 5/24/12 Lebanon, Indiana f Funeral Service Licensee 22. Name and Address of Facility Metropolitan Funeral Service . Signatur 5517 Vine St. Alexandria, VA 22310 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest r heart failure. List only one cause on each line. 23a. Parl 1. Enter the dis shock, dr heart failu Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ ase or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Other (specify) 5 the 9 Unknown 9 Unknown Division of Vital Records, P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 e Hospital or Attending Physician: The law requires 124 hours after death.

Puneral Director: After this certificate has been sign eletay filled in by the funeral director, page 2 should be letely filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1- Natural 5 Pending injury 2 🗌 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one the 29b. Signature 29d. Date signed (Month, Day, Year) 2

3 m

Registrar
DHMH 17 Rev 06-2011

State

10110 Molecular Dr. #206 Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Marichu Matas, M.D.

31. Date filed (Month, Day, Year)

NAY 3 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ GOYAM uther Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPIT Johns HOPKINS If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month, Day, Ye
May 7, 1 Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Months 171-24-5585 **Director** 1 🛣 M 2 🗆 F 82 1930 Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford 1 Yes 2XXNo Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 204 Hopewell Road 21028 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Yes 2 □ No 1948 If Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: white Completed 3 Widowed 4 Divorced Year or Dates. 1990 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) MD National Guard 12 Military Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ida Jacobs Luther A, Hahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Jane Hahn (wife) 204 Hopewell Road, Churchville, MD 21028 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 5/31/2012 ens 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Harford Memorial Gard 4 ☐ Donation 5 ☐ Other (Specify) Aberdeen, Maryland 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service Licensee coste Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition Medical resulting in death) Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Month Year ate has been signed by the a page 2 should be detached for 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🖾 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29c. License number 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAUSHIK MANDAL 1800 Baltimore Orleans NAY 3 0 2012 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Louis Hardy 05 2012 Medical 24 10:20 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) 06/19/1924 Director X M 2 D F 421-24-2585 87 Alabama Usual Residence of Deceder 2 should be filed within 72 hours after death with the Meryland thit end Mentel Hygiene. 27 is marked other then "netural", or items 23e or 28e-f show trumatic event, the Mer Terland trunct be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director X ☐ Yes 2 ☐ No MD Harford Edgewood 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 635 Boxelder Drive 21040 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married Black, White, etc. \$ 1 Yes No Baltimore, Maryland 21215-0036 1 ☐ Yes X ☐ No Specify: 3√ Widowed 4 Divorced Specify: Completed Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only high grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 1 end 2 should to of Heelth end Me item 27 is mark <u>Sam Hardv</u> Annie Mae Mosley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pege 1 end 2 Depertment of Heelth Importent: If Item 27 eny Injury or other tr Karla K. Simon / Daughter 635 Boxelder Drive, Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Durial X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 5/25/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician disease or condition CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physiclen and s the buriai-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 98 ettending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate hes funeral director, page 2: 1 🗆 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical Division of Vital 8 26. Place of Death (Check only one) Other: 2 💢 No Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 K Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death,

To the Funeral Director: Aft
completely filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

DHMH 17 Rev 06-2011

State

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

TRACIE L. MORGAN,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **EDWARD** JAMES HOSKINS May Month Day 201°2 23 4:59 p M Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Greater Baltimore Medical Center Towson Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Hours 142-32-0020 **Director** 1 🛛 M 2 🗆 F 70 JAN 15 1942 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified MD 28a-f BALTIMORE NA 1X Yes 2 No 10e, Street and Number ō 10f. Zip Code ms 23a or must be i 10g. Citizen of What Country? Funeral 2121 HOLDER AVENUE 21207 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ed other than "natural", or itelevent, the Medical Examiner rmed Forces?

X Yes 2 \sum No Black, White, etc Completed by 1 Never Married 2 Married If Yes, Give 1964 - 66 Year or Dates: 1 ☐ Yes 2 🙀 No Specify 3 Widowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) POSTAL CLERK US POST OFFICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ EUGENE BUSTER HOSKINS ANNIE HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. FRANCINE SANDERS- FRIEND 2121 HOLDER AVE. BALTIMORE, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) GARRISON FOREST VET. JUNE 6 2012 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4300 WABASH AVE. MARCH FUNERAL HOME WEST, INC. BALTO. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Probable disease or condition resulting in death) myocardial Medical Due to (or as a consequence Examiner Due to (or as a consequence of): Artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day detached 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Disbete Mellitis, Chronic Kidney 2 1 Ses 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hyperterson 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? this certificate 1 Yes 2 No Yes Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death al or Attending P s after death. I Director: After to d in by the funera Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work

P.O. Division of Vital Records, Mental

ltimore,

within 24 hours a

To the Funeral C To the Hospital Registrar

MITEH TRANSPORT State

29a. Certifier

(Check

only one

29b. Signature and title of certifier

2 Accident
3 Suicide

4 Homicide

Investigation

determined

6 Could not be

29c. License number 00066584

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Yes 2 No

21204

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the control my knowledge, death occurred at the time date and place, and the cause(s) and manner stated. arrad at the time, date and place, and due to the 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5/24/12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N. CHANLES ST TOWARH. MD

31. Date filed (Month, Day, Year, 2. Registrar's Si

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 16	8	į	{
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	1- For State Registrar			Cert	tificate of	Death		R	eg. No.	4.2 100.
Physiciar Medical Examin	1. Decedent's	Name (First, Midd		raig E	Heberle	Jr.		2. Date of Dea Month May 26, 2	Day Year	1230 nrs
		ame (if not institution seph's Hospit	on, give street and number)	4	b. City, Town, or L Towson	ocation of Death	1	4c. County of Baltimore	
Funeral Director	5. Social Sect 213–98	- 7427	6. Sex 7. As	ge (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min	-	rth(MM/DD/YYYY) 5/1981	9. Birthplace (State or Foreign Country)Maryland
ма вод	Usual Reside 10a. State MD	10b. County		10c. City, 7	Town or Location		imore			10d. Inside City Limits 1 XX Yes 2 No
Maryland r 28a-f show	10e. Street an	d Number Washingt	on Boulevard			10f. Zip Code	1230]1	0g. Citizen of Wh	
		atus	12. Was Decedent	t Ever in U.S		Decedent of Hisp s, specify Cuban,	anic Origin? (S		14. Race White	- American Indian, Black, , etc.
7	15. Deceder Elementary	it's Education (Spe /Secondary (0-12) 9th		. ,	during mo	st of working life. [Service]	00 NOT use ret Worker	red)		vate
21215-0 21215-0 suld be filed w Mental Hygie marked athe cevent, the A	Theresa Gail Abbott 17. Father's Name (First, Middle, Last) Ronald Schreffler Jr. Theresa Gail Abbott									
MD 21 12 should th and Me 127 is ma umatic ev	9th Food Service Worker Primary of the state									
Theresa schieffler (Mother) 2309 Washington Boule 20a. Method of Disposition 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Fungral Service Licenses 22. Name and Address of Facility Phi 2431 E. Oliver Str								Date -/2012	20c. Location -	City or Town, State
Baltil permit. Departm Importa	21. Signature	of Funeral Service	Licensee		243	31 E. Oli	ver Str	reet, Ba	ltimore	ford FS,P.A. MD 21213
Physician	failure. L	iter the disease, or ist only one cause iuse (Final disease	35 . 1 1				uch as cardiac o •	r respiratory arr	est, shock, or hea	Approximate Interval Between Onset and Death
Examiner		esulting in death)	Due to (or as a cons							
	if any, leading cause. Enter (Disease or in		Due to (or as a cons							
execul an and al - tra			d. X AMENDED #1	as not	ted,23a	,27,28a-1	f,per me	e,g928 (5-8-12 sr	n.
Il Records, P.O. Box 68760, a: The law requires that the death certificate be rifficate har been signed by the attending physici or, page 2 should be detached for use as the burnior, page 2 should be detached for use as the burnior.	IF FEMALE: 23b. Was dece past 12 m	edent pregnant in to onths?	I LITTLIVE DITTIL		2 Feta	al death 3	Ectopic pregna	ancy	23d. Date of o	delivery Day Year
Tr the death certification by the attending ached for use as:	1 Yes 2		known 9 Unknown		3 Oui	er (Specify)	en in Part I	23e. Did to	obacco use contrib	oute to the cause of death?
P.C es that	<u>a</u>	organicant cond.	and the contributing to deat	TO DEL FIOL FO.	suning in the un			1 Yes	s 2 No 3	Probably 4 🗹 Unknown
Lecords The law required har been age 2 hould	Completed ———							24a. Was autop perfo 1 Yes	osy pr rmed? de	Vere autopsy findings available rior to completion of cause of eath? Yes 2 No
Vital Relations The this certificate director, page	25. Was case examiner?		Characteria and	ent 2 🗸 E	ER/Outpatient		of Death (Check		Residence 6	Other:
of Ph.	27 Manner of	Death 5 Pen	28a. Date of Injugation ding stigation 28a. Date of Injugation (Month, Day, Value)	(ear)	28b. Time of Inj	_ 1□ ve	at Work?		how injury occurre	ed medications
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: Complete [filled in by the filled in the pure filled in the filled in the pure filled in the p	3 Suicid	e 6 Cou	ld not be 28e. Place of Ir		me, farm, street Light R	, factory, office bui	ilding, etc.	or Town, S	Street and Numbe State) Light keysvil l	r or Rural Route Number, City Rail at Shawan Le,MD.
5 - 5 > 1	(Check only		hysician: To the best of m miner: On the basis of exa and manner stated.	ny knowledge mination an	e, death occurre d/or investigatio	ed at the time, date on, in my opinion, o	e and place, and death occurred a	due to the caus at the time, date	se(s) and manner and place, and du	as stated. ue to the cause(s)
	29b. Signature	and title of certific			1	29c. License O.C.M			29d. Date signe May 27, 20	d (Month, Day, Year)
ours.		address of persor Alexander MI	n who completed cause of D. Assistant Medic	- market	•	V. Baltimore S	Street, Baltin	nore, MD 21	223	
Star Registra		(Month, Day, Year)		ar's Signatur	bare)				
DHMH 17 Rev 1/200			755	1	ORIGINAL		-		OME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 21° 8:33 P M 2012 Margaret Child Ink Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rockville Montgomery Casey House If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth Funeral Min (Month, Day, Year) Director 483-24-6165 1 M 2 K F 87 Dec 5. 1924 Iowa 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 27 is merked other then "neture!", or items 23e or 28e-f s traumetic event, the Medical Examiner must be notified 1 Yes 2 X No Gaithersburg MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20878 310 High Gables Drive #306 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Pege 1 end 2 should be filed within 72 hours efter Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: 3 Widowed 4 X Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Performing Arts Musician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Blanche Lytle Child f Heelth er. m 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1115 Elway St. #310 Saint Paul, MN 55116 Lauri Ink / Daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1 Burial 2 D Cremation 3 Removal from State Importent: If any Injury or once. Journey Crematory 5/25/2012 4 Donation 5 Other (Specify) Woodbine, Maryland <u>nal</u> . Signature of Funeral Service Lie Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Breast Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): ettending physicien end for use es tha buriel-trensit or Attending Physician: The lew requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month Day 5 Other (specify) Pregnant at time of death sate hes been signed by the page 2 should be deteched q Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 2 No efter deeth. | Director: After this certificate to a ln by the funerel director, peg 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSpice 2 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 5 Pending Investigation 24 hours efter der se Funerel Director bletely filled in by the 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely f (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) e and title of certifier 29d. Date signed (Month, Day, Year) 5.22.12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller 6001 Muncaster Mill Rd. Rockville, MD 20855

Registrar

DHMH 17 Rev 06-2011

State

32. Registrate Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ $\underline{\mathbf{A}}\mathbf{M}^{\mathsf{M}}$ 10:12 2012 Susan Jane Jones May 11 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 33 Ridge Road #J Greenbelt Prince George's If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 9. Birthplace (State or Foreign 5. Social Security Numbetink 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year, Director 1 □ M 2 🗓 F Yrs July 25, 1940 71 Usual Residence of Decedent 28a-f show 10c. City. Town or Location 10d. Inside City Limits ms 23a or 28a-f shomust be notified at 10a State Director 1 Yes 2 No MD Prince George's Greenbelt 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral 2077Q USA 33 Ridge Road #J Was Deceue.
Armed Forces?
Vas 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Black, White, etc. ö 1 Never Married 2 Married by Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify Specify: White natural", 3 Widowed 4 Divorced led who.

al Hygiene.

ad other than "natural"

the Medical E. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry unk life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk Be unk filed unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental H 1 and 2 should be fill of Health and Mental item 27 is marked of ပ traumatic un 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Don Inscoe/PGFI 900 W. Balto. ST. Balto.MD 21223 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State injury or Department Important: If any injury or once, 4 □ Donation 5 🗓 Other (Specify) in state e Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director 12 timore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph i ian disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) and the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical certificate be P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day the a 9 Unknown been signed by the should be detached Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 binknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? has page 2 of aftending Physician; The after death.

Director; After this certificate It Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) \(\frac{5}{\text{Residence}} \) \(\text{Residence} \) \(6 \) \(\text{Other (Specify)} \) 1 Yes 2 □ No ျ ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🗀 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1- Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completely filled the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 16821 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ James John Jaskiewicz, May 2012 8:48A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 9881 Edisto Way White Marsh Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Days Hours 214-62-8957 61 **Director** Baltimore, Maryland October Usual Residence of Decedent 28a-f shov 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Baltimore White Marsh 1 Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be Funeral 21236 United States 9881 Edisto Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deced Armed Forces? ✓ ☐ Yes 2XXNo 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry permit. Page 1 and 2 should be flied within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meconce. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James John Jaskiewicz, Sr. Virginia Zimmerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Neyer (Sister) 742 Seawall Road Essex, Maryland 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Evans Funeral Chapel-Bel May 27, 2012 Forest Hill, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Puneral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. el & Cremation Services Parkville Parkville, Maryland 21234 Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) a consequence of): Examiner COCUZ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine or as a consequence of) death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): nding physiciar 000 Physician/Medical P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 L Fetal deal Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Dav Year ped Hospital or Attending Physician: The law requires that the signed by to d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s yes 2 certificate 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) <u>, 2</u> 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 5 Pending Natural 2 🗆 No within 24 hours after death To the Funeral Director: A Accident 1 Yes Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number D0024303 05/25/2012 State Registrar

amend 20b, per fh,g927 5-30-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For	State of Maryland / Department of Health and Mental Hygiene								
1.	State Registrar		Certificate of De		Reg. No. 2012	16822				
Physician/ Medical	Ella R. Jo	hnson		2. Date of De	eath 26 2012	3. Time of Death				
Examiner ^{4a}	Facility Name (if not institution, give	HOSPITAL	4b. gity, Town, or L	ocation of Death MORE	4c. County of Death					
Funeral 5. Director	Social Security Number 1 Security Number 1 Security Number 6 Security Number 1 Jsual Residence of Decedent	7. Age (In yrs. last b	irthday) If Under 1 Year Months Days Yrs.	If Under 24 Hrs. 8. Date of Bi Hours Min. (Month, Di 2119		place (State or Foreign				
Maryland 28a-f shov atified at rector	Da. State 10b. County		un or Location Itimore			10d. Inside City Limits 1 √Yes 2 □ No				
leath with the Maryland items 23a or 28a-f she er must be notified at Funeral Director	800 Wildwoo	10 1	10f. Zip Code 212	29	10g. Citizen of What Cour	ntry?				
2.5	. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No		Black, White,					
21215-0036 within 72 hours after gene. than "natural", o the Medical Exam Completed by	15. Decedent's Ed (Specify only highest gra- Elementary/Serbindary (0-12)		ia. Decedent's Usual Occupati (Give kind of work done dur Je. DO NOT use retired)	ring most of working	Health	Care				
Maryland 2 2 should be filed v th and Mental Hyg 27 is marked othe traumatic event,	Father's Name (First, Middle Hst)	mas		18. Mother's Name (First, Middle	Haiden Surname) Emery					
b, Mary and 2 should lealth and M m 27 is man her traumat	Allormant's Name/Relationship (Tylelvin Emor	1 (Son) 8	DO Wildwo	d Number of Rural Route Number	Baltmar	e, MD				
ti. Partiment transfer transfe	a. Method of Disposition 1	Removal from State Cemei	Nawoska thedral try, cremato for other place)	y 6-1-12	Baltmar	own, State				
	Signifure of Funeral Service Licens	C. Preise	515172	to. Nating	Pike (212	Services 279)				
Ph, i i.n/	3a. Part 1. Enter the disease, or comp shock, or heart tallure. List only of nmediate Cause (Final isease or condition soulting in death)	olications that caused the death. Do	o not enter the mode of dying,	such as cardiac or respiratory a	rrest,	Approximate Interval Between O set and Death				
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vecuted all-trans	any, leading to immediate ause. Enter Underlying ause (Disease or injury ant initiated events esulting in death) Last	c. Due to (or as a consequence								
icate be expression of physiciar is the burit		d								
ith cer (it and in a sign)	FEMALE: b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown			23d. Date of delive	ery Day Year				
	art II. Other significant conditions co	ontributing to death but not resulting	g in the underlying cause giver	250. 514	robacco use contribute to the	_				
Reco				24a. Was auto perfi 1 □ Yes	ormed?death?	psy findings available mpletion of cause of				
f Mtal Re Physician: The Physician: The ral director, pac i: To Be Co	. Was case referred to medical examinar?	Hospital:	Other	e of Death (Check only one)						
by b	. Manner of Death 1 ☑ Natural 5 ☐ Pending	1 Inpatient 2 Inpatient 2	Outpatient 3 DOA Time of linjury a work?	t 28d. Describe	dence 6 Other (Specify how injury occurred)				
Sion with the single of the si	2 Accident Investigation 3 Suicide 6 Could not be determined		M 1 □ Y∈	28f. Location (City or Tou	Street and Number or Rural vn, State)	Route Number,				
	(Check 2 Medical Examin	ician: e best of my know) dge	or investigation, in my opinion,	death occurred at the time, date	and place, and due to the car	use(s) and manner stated.				
To the complex complex Section 10 to the Section	only one) 3 Certifying Nucleon b. Signature and title of certifier	e Practitioner: To the best of my kn	owledge, death occurred at the 29c. License n		the cause(s) and manner as s 29d. Date signed (Month, I					
λ	. Name and address of person who c	ompleted cause of death (Item 23a)	Type, Printy	0000	= 126/2 21229	Q.S.				
State State Registrar	Date filed (Month, Day, Year) NAY 3 0 2012	32. Registrar's Signature	ake							

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Maurice Donald Jo	•	ISON I- For State Registrar	State	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012 1682									
Physician Medical Examine	1/	1. Decedent's Name			14.16.	. /			2. Date of De Month	ath Day	Year		of Death
Wedical Examina		4a. Facility Name (if	not institution, give				b. City, Town, or	Location of Dea	May 19,	2012	. County of D		4 hrs
,		Johns Hopki					Baltimore						
Funeral Director		5. Social Security No			ge (In yrs, Ia	01	If Under 1 Year Months Days		in.	1	1 _F c	. Birthplace (oreign	
	ŀ	213-96- Usual Residence of		M 2 F		<i>21</i> Yrs.		1	10/2	6/1	980	Country)	MD
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Maryland 28a-f show d at once.	į.	M D 10e. Street and Num	shor.		BF	ALTIM	0 RE 10f. Zip Code			10. 0	C1AH		Yes 2 No
he Mar or 28s	2		IMORA	AVENUL	<i>C</i>		212	213		TOG. Citi	zen of What		
ms 234	_ L	11, Marital Status		12. Was Deceden	t Ever in U.S		Decedent of His	panic Origin? (0-	14. Race - A	merican India	n, Black,
er deat	-	1 Never Marries 3 Widowed	_		No		es, specify Cuban, Yes 2 — No	•	to Rican, etc.)		White, et	c. BLACK	
ours aft	3	15. Decedent's Edu		or Dates:	mpleted)	16a. Decedent	's Usual Occupati	on (Give kind o	f work done		Specify:		`
n 72 hc		Elementary/Secon	ndary (0-12)	College (1-4 or	5+)	_	est of working life. ϵ		etired)	M	Capal	CK &	Schmick
d withing ygiene.	paraidulos	17. Father's Name (F	First, Middle, Last)	<u> </u>		LIN			ne (First, Middle,	Maiden	Surname)	ier 6	
21215 ald be file Mental H. marked o		Louis Ru 19a. Informant's Nan	IDOLPH	JOHNSO	N			MARCE	11a H	01101	nan		
O 8 5 2 2 7	2	19a. Informant's Nan Marcell	ne/Relationship (Ty	pe, Print)	ther	19b. Mailing	Address (Street	and Number of	Rural Route No	moer Ci	LY OF TOWN S	tate, Zip Cod	(e)
ore, MI st and 2 s of Health an If item 27	ľ	20a. Method of Dispo	osition		20b. P	lace of Disposit	E/MOR	netery,	Date	20c. L	ocation - Cit	y or Town, St	ate
		1 Burial 2 2 4 Departion 5	Other Specify:	Removal from S	tate GR	rematory or oth REEN M	OUNT ame and Address OS YORK	6/	4/2012	E	BAUI	MIRE	MO
Baltimo permit. Pag Department Important:	-	21. Signature of Fun		ee		22. Na	ame and Address	of Facility	HUGHN	GRE	SNE F	INGLA	escrs
Physician	+	23a. Part I. Enter the			d the death. I	Do not enter the	e mode of dying, s	such as cardiac	or respiratory ar	rest, sho	Ck, or heart	Approx	imate Interval
Examiner	1	failure. List only Immediate Cause (F	one cause on eac inal disease a. T	th line. Wo Gunshot V	Vounds o	f Chest							en Onset and Death
Examiner		or condition resulting	in death)	ue to (or as a cons	equence of)	:							
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red List		Cause Enter Under (Disease or injury that events resulting in de	at initiated C	ue to (or as a cons	equence of)							- 3	
and transit	<u> </u>		d	·									
6 be executivistical and burial - tra		UNPENDED		AMENDED									
cat 68760 eath certificate be attending physic for use as the bu	2	F FEMALE: 3b. Was decedent properties past 12 months?	regnant in the	23c. If yes, outco		2 Feta	al death 3	Ectopic pregr	nancy		. Date of deli Month	very Day	Year
). Box 68760 the death certificate to the attending physiched for use as the by Physician/Me		1 Yes 2 No	_	4 Pregnant at	t time of dea	th 5 Oth	er (Specify)		10.000	1389			
		Part II. Other signific	cant conditions	contributing to deat	h but not res	sulting in the un	derlying cause gi	ven in Part I.	23e. Did t	obacco u	se contribute	to the cause	of death?
S, P.(uires that n signed ld be deti	3		 								No 3 F	Probably 4	Unknown
Records, : The law requires fiffcate has been sign, page 2 should be Completed							-		24a. Was auto			to completion	ings available of cause of
tal Reciding: The certificate rector, page		25. Was case referre	d to modical				20 Dlass	of Dooth (ÖlI	1 Yes	2 No			2 No
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the staff death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Commisted by D.	5/	examiner?	¡Ho	spital: 1 Inpatie	ent 2 🔲 E	R/Outpatient	10	of Death (Check Other Nursi	ing Home 5	Resider	ice 6 O	ther:	
ding Ph After t funeral	1	27. Manner of Death		28a. Date of Inju (Month, Day.) May 19, 2012	ury (ear)	28b. Time of Inj			28d Describe Subject sho			-	
Sior Attend or death. rector: by the i		2 Accident	5 Pending Investigation	1			factory, office bu	es 2 V No	·			D. I.B. I	
Division o Hospital or Attending 24 hours after death. Funeral Director: Aftered filled in by the fune		3 Suicide 4 ✓ Homicide	6 Could not be determined	(Specify) To			='	iliding, etc.	28f. Location (or Town, 3 3531 Elmore	State)			Number, City
Di To the Hospital within 24 hours a To the Funeral completely filled		29a. Certifier 1 C	ertifylng Physicla	//			ed at the time, date						-
To the Ho within 24 To the Fu complete!		2 M 29b. Signature and tit		and manner stated.	mination and	d/or investigatio	29c. License		at the time, date			o the cause(s	
			1//				O.C.M				20, 2012	vonai, Day, Y	odi)
OCME	3	30. Name and addres	17		, –	,							
		Mary G. Ripp		uty Chief Medi			V. Baltimore	Street, Balti	more, MD 2	1223			
State Registra	~	1. Date filed (Montir,	LY On 201	32. Registra	s signature	Le	الما						
DHMH 17 Rev 1/2001		147	11 0 0	- Land	~ 10	ORIGINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 16824 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Manth y 6930 AM Rosetta Deloris Johnson 2012 Medical Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death saltimore Age (In vrs. last birthday) 8. Date of Birth (Month, Day **Funeral** If Under 24 Hrs 9. Birthplace (State or Foreign 1 - M 2 7 F Year) Country) Director 83 215-24-2888 09 Usual Residence of Decedent show 10a. State 10b. County at the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified MD NA 28a-f Baltimore 1 X Yes 2 □ No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r with t Funeral 5025 Pimlico Road 21215 U.S.A. items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ò þ 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify "natural" Completed 3 Widowed 4 □ Divorced Black er than "natura 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working College (1-4 or 5+) Elementary/Seconday (0-12) 12th grade Westinghouse other na <u>Circuit Board Technician</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H

27 is marked of
traumatic ever ည James Singletary Jannie Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health a t; If item 27 is or other train Janice K. Mugar-Niece 5025 Pimlico Road, Baltimore, Md 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State Department or Important; If any injury or once, 4 Donation 5 Donation Other (Specify) Memorial Park 5/26/2012 Woodlawn, Md 21. Signature of Fun ral Service Lice 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Deat Physician CARDIAC disease or condition resulting in death) Medical Examiner Due to (or as a consequence of **>10415** quentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Day Month Year 2 No the Unknown g Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ensign 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an after death.

Director: After this certificate has autopsy page performe death? Yes 2 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes ျ 1 Inpatient 2 FR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural (Month, Day, Year) 5 Pending ☐ Accident ☐ Suicide 1 🗌 Yes 2 🗌 No Investigation М the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and Atl MAY 25, 2012

DHMH 17 Rev 7/2009

State Registrar cause of death (Item 23a) (Type, Print

D68628

12-03857

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2012 16825 State of Maryland / Department of Health and Mental Hygiene Ava Lucinda Jacob Certificate of Death 1- For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 1259 hrs May 20, 2012 Ava Lucinda Jacob Medical Examine 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Harford **Bel Air** Upper Chesapeake Medical Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) Months Days Hours Min 014-66-0889 10/19/1968 Director 43 Massachusetts 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 Xio MD Harford Belcamp 28a-f show narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once. within 72 hours after death with the Maryland Directo 10g. Citizen of What Country' 10f. Zip Code 10e Street and Number 1459 Golden Rod Court 21017 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or Nouneral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Married Black Yes Specify: Yes 2 X No specify: If Yes, Give Year Widowed 4 X Divorced 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired)

Nurse's Aid Completed College (1-4 or 5+) Medical Elementary/Secondary (0-12) imore, MD 21215-0036
Pages 1 and 2 should be filed within 7
nent of Health and Mental Hygiene. 9 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Benjamin Jacob Ethel Sullivan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) rtment of Hearn, ortant: If item 27 is Stephanie Johnson Jacob / Daughter 1459 Golden Rod Court, Belcamp, MD 21017 20c. Location - City or Town, State 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery Date crematory or other place) Chesapeake Crematory 5/30/2012 Beltsville, MD Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee injury Maryland Cremation Services, PO Box 1413, Baltimore, MD 21203 Manita mas 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and Death /Medical a Probable Pulmonary Embolism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial - transi Physician/Medical AMENDED UNPENDED 23d. Date of deliven 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions o Yes 2 No 3 Probably 4 ✔ Unknown <u>≨</u> Obesity; Hypertension; Hyperlipidemia; Uterine fibroids Δ. Completed 24b. Were autopsy findings available Records, 24a. Was an prior to completion of cause of autopsy death? certificate has Yes Yes 2 V No 26. Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Tai-25. Was case referred to medical Be Hospital: examiner? Nursing Home 5 Residence 6 DOA Inpatient 2 V ER/Outpatient 3 1 V Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification 1 V Natural Yes 2 Pending Director: Investigation 2 Accident 28f. Location (Street end Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) Suicide Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) **Medical** and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 21, 2012 O.C.M.E Var 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Carol Allan, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signatur

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ee Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner HODD140 014 IMOR 8. Date of Birth (Month, Day, last birthday If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Min 1 XM 2 □ F Director 10c. City, Town or Location shov 10a. State 10b. County 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No 10re 10g. Citizen of What Country? Street and Number 10f. Zip Code ò must be Funeral 23a 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married Ь þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Black Specify: "natural" Completed 3 Widowed 4 Divorced th and Mental Hygiene.
It is marked other than "natun traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Elementary/Secondary (0-12) Be Father's Name (First, Middle, Last) ၉ hannon 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shannon nt of Health a 21213 other t 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, State Department of Important: If it is any injury or c Burial 2 Cremation 3 Removal from State Denation 5 Other (Specify) ignatu of Funeral Service L 22. Name and Address of Facility East 1101 E. Nort 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between iate Cause (Final Onset and Death Ph, sician/ METASTATIO se or condition Medical Iting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of) burial-transi and Due to (or as a consequence of) attending physician To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregna☐ Other (specify) Ectopic pregnancy Live Birth 2 ☐ Fetal deat
Pregnant at time of death for in the past 12 months?

1 Yes 2 No Year Month Day signed by the at Id be detached for Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Yes should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an autopsy performed? Yes 2 cate has t completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 - Pending work? 2 No Accident Investigation Suicide Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 181 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

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ORIEANS

Cohen, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 17:12 M ison Medical 4a. Facility Name (if not institution, give street and number Examiner City, Town, or Location of Death 4c. County of Death Johns imure 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days (Month, Day, Year) Hours 253-48-3196 Director 1 X M 2 □ F 79 Yrs Sep. 18, 1932 Pennsylvania th end Mentel Hyglene. 27 is marked other than "natural", or iteme 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford Maryland Bel Air 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1318 Brushing Lane 21015 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 - Widowed 4 - Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Carl Eric Johnson Mildred Grace Collin permit. Page 1 and 2 should be Department of Health end Men Importent: If Item 27 is marke eny injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ilga Z. Johnson / Wife 1318 Brushing Lane, Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 XBurial 2 ☐ Cremation 3 ☐ Re ioval fre m State Darlington Cemetery 5/30/2012 Donation 5 11 Other (Specify) Darlington, Maryland 21. Sign 22. Name and Address of Facility McComas Funeral Home, P.A. Þ 50 W. Broadway, Bel Air, Maryland 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Olorecta disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hoepital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burlar-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day 1 Yes 2 No 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 Yes **Division of Vital** 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES - 000 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KIM Reiss 1800 Coroline Baltimore, Maryland saroline 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar

amend 31,per DVR,g927 5-30-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of E	peatn	2. Date of Death	j. No. ∠ U	12	3. Time of Death
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-	Examin		4a. Facility Name (if not institution, give str	_			Location of Death		4c. County of		
			10564 Gateridge Ro 5. Social Security Number 6. Sex	ad 7. Age (In yrs. Ia	st hirthday)	Cockey	SV1LLE If Under 24 Hrs.	8. Date of Birth		timo:	re ace (State or Foreign
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	h the	al D	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh		ry?
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980	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Fi	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		White, e	tc.
215-0036	hours, hours	plete	15. Decedent's Edu (Specify only highest grade	cation		dent's Usual Occupa	ation during most of worki	na 1	6b. Kind of Bus	iness/Ind	ustry
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Baltimore,	t. Page tment tant: It		1 X Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	Mer	norial	Gardens	5 - 29		imonium		Maryland
Bal	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra once.			gan	7 7	1050 York		Towson, M	laryLand	i HC	me, me.
Ļ	Physician/		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition	cations that caused the death cause on each line.	h. Do not ente	er the mode of dyin	g, such as cardiac o	Faut	ion_	41	Approximate Interval Between Oriset and Death
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Box 687	the Hospital or Attending Physician; The law requires that the death certificate be executed frin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 pop fis? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of o	al death 3	Ectopic pregnand Other (specify)	cy		23d. Date Mont		ry Day Year
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ίV	Physi this c	2	1 ☐ Yes 2 ☐ No ☐ ☐ Yes 2	1 Inpatient 2	ER/Outpatie		4 ☐ Nursing Ho	ome 5 X Residen 28d. Describe how			
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Division of Vital	al or Attendi s after death. Il Director: A ed in by the f	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (Stre City or Town,		or Rural	Poute Number,
	To the Hospital or Attending Physician; The la within 24 hours after death. To the Funeral Director. After this certificate ha completely filled in by the funeral director, page	Medical	(Check 2 Medical Examine	cian: To the best of my know er: On the basis of examination Practitioner: To the best of r	n and/or inves	tigation, in my opinio	on, death occurred a	t the time, date and	place, and due t	to the cau	se(s) and manner stated.
	To the within To the comple		29b. Signature and title of certifier	ter M	D	29c. Licenso	e number 28594	29	d. Date signed $5/2$	(Month, E	ay, Year)
7			30. Name and address of person who co	mpleted gause of death (Item	Stre	et#21	o Bal	time	Ma	Zi	204
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa		Lune	1. ba	Kal			

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 16829 Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:03 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death tospita 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months Hours Min. Director 1**₹** M 2 □ F b2/13/1949 Maryland 63 er then "naturel", or items 23a or 28a-f show the Medical Evarriner must be notified at 10b. County within 72 hours efter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD N/A 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21205 U.S.A. 803 N. Luzern Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Ves 2 No δ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 end 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "na any injury or other treumetic event, the Mediconce. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver U.S. Foods 10th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jessie Dixon Willis Lee Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
803 N. Luzerne Ave., Baltimore, MD 21205 Rose Allen (Aunt) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐xCremation 3 ☐ Removal from State 5-23-12 Baltimore, MD on-site Crematory: 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licely 27 Wise of Middle of FB Fown Jr. Funeral Home MD 21217 2140 N. FUlton Ave., Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ MTE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Que to (or as a consequence of): To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicien and Cause (Disease or injury attending physicien and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No 1 🗌 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plans, and due to the cause(t) and manner at state of the course of the time, date and plans, and due to the cause(t) and manner at state of the course of the time, date and plans, and due to the cause(t) and manner at state of the course of the time, date and plans, and due to the cause(t) and manner at state of the course of the time, date and plans, and due to the cause(t) and manner at state of the course of the time. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D1800 TERUVU

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101		artment of Health	and M	ental Hyg	jiene	10	10020
			State Registrar	Cer	tificate of Death		_	Reg. No. Z U	12	16830
	Physicia Medic		1. Decedent's Name (First, Middle, Last)	26			2. Date of Deat	9 Pay 201	Year 2	3. Time of Death
	Examir	ner	4a. Facility Name (if not institution, give street and number) 1018 Kevin Rd.	4	4b. City, Town, or Location	of Death	,	4c. County		
	Funeral			yrs. last birthday)	Baltimore If Under 1 Year If Under	r 24 Hrs.	8. Date of Birth		/A 9. Births	place (State or Foreign
á	Director		220-78-9114 1 🕸 1 🕸 2 🗆 F	52 Yrs.	Months Days Hours	Min.	(Month, Day, 04/29/		Coun	yland
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or Loc	cation		04/29/	1900		0d. Inside City Limits
	Maryla 18a-fs tiffied	Director	MD N/A		Baltimore					1 □ X ′es 2 □ No
	ith the I 3a or 2 t be no		10e. Street and Number 1018 Kevin Rd.		10f. Zip Code 21229			10g. Citizen of V		ntry?
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever		Vas Decedent of Hispanic Ori	igin? (Speci	ify Yes or No-		e - Americ	an Indian,
336	within 72 hours after death with the Maryland jiene. br than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at the Medical Examiner.		1 X Never Married 2 ☐ Married If Yes 2 ☐ Molo If Yes Give Year or Dates.		f Yes, specify Cuban, Mexicar ☐ Yes 2 XNo Specify:		ican, etc.)		k, White, o	
2-0(hours "natur dical l	plete	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation kind of work done during mos	et of working	,			own Square
2121	within 72 rgiene. ner than '	Completed by	1 2 th Grade College (1-4 or 5+)	life. DO	Main Tech	St Or WORKING	9	Apar	men	ts
Baltimore, Maryland 21215-0036	filed al Hy ven	To Be	17. Father's Name (First, Middle, Last) William Johnson				(First, Middle, N	Maiden Surname	*)	
Man	of and 2 should be of Health and Ments fitem 27 is marked rother traumatic e		19a. Informant's Name/Relationship (Type, Print) Dontae Johnson(son)		g Address (Street and Number Stranden R			City or Town, S More,		
more,	age 1 an ent of He nt: If item ry or othe		1 XPurial 2 Cramation 2 Demoual from State	20b. Place of Dispose cernetery, crem. Mt. Zio	sition (Name of natory or other place) n Cemetery		- 1	20c. Location -	-	
Baltii	permit. Page Department of Important: If any injury or once.		21. Signing of Fun ral Service Literage	F	overhadnes of Brit 140 N. Fult	own i	Jr. Fu	neral	Home	e PA
	- 1		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						1	Approximate Interval Between
3	Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a co	- Cance	x				\perp	Onset and Death
	Examiner	Į.	Sequentially list conditions b.						_	
	uted d ansit	amine	nany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	neaquanta oly.						
	ate be executed physician and the burial-transit	dical Examiner	resulting in death) Last Due to (or as a co	nsequence of):						
292	icate k p phys	fedic	d							
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of p. 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	J Fetal death 3 ∟	Ectopic pregnancy Other (specify)			23d. Da Mo	te of delive	ery Day Year
P.O.	es that the dea signed by the a I be detached f	by Ph	Part II. Other significant conditions contributing to death but no	ot resulting in the ur	nderlying cause given in Part	1.	23e. Did tob	bacco use contr	ibute to th	ne cause of death?
rds,	requires been sig should b						1 🗆 Ye			pably 4 Unknown
Division of Vital Records,	The law resate has by	Completed					24a. Was ar autops perforr 1 Yes	med?	Were autop orior to cor death? 1	osy findings available mpletion of cause of
ital	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{M} \) No Hospital: 1 \(\text{Impatient} \)		26. Place of Dea		21			<u> </u>
of V	g Phys er this ieral di	e: To	27. Manner of Death 28a. Date of injury	2 ER/Outpatien 28b. Time of	t 3 □ DOA 4 □ No 28c. Injury at			ence 6 Other)
on	ttendin death. :tor: Aft	fical	1 Natural 5 Pending (Month, Day, Ye. 2 Accident Investigation 3 Suicide 6 Could not be	ear) injury	M vork?	No				
Sivisi	al or Attending Is after death. I Director: After ed in by the funer	Certificate:	4 Homicide determined 28e. Place of Injury - building, etc. (Sp.	At home, farm, stre pecify)	et, factory, office	28	Bf. Location (Sta City or Town	reet and Number, State)	er or Rural	Route Number,
_	To the Hospital or Attending Physiciam: within 24 hours after death, within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check conly one) 1 Certifying Physician: To the best of my leading the conly one conly on	ination and/or investi	igation, in my opinion, death o	ccurred at the	ne time, date an	d place, and due	e to the cau	use(s) and manner stated.
	Vithi Com		29b. Signature and title of certifier		29c. License number	101	2	9d. Date signed	(Month, L	Day, Year)
			30. Name and address of person who completed cause of death	(Item 23a) (Type, P	rint) RII	101	10100	3/19	100	2 2011
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's S	Signature	MUN DING	1, , ?	Laus	-NW	IND	21.784
	Registra	ar	MAY 3 0 2012 June	8. Back						

DHMH 17 Rev 06-2011

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-f show

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"natural", or items 23a

other

injury or other traumatic

ages 1 and 2 should be fill out of Health and Mental Ht: If item 27 is marked out

permit. Pages 1
Department of H
Important: If itel

the Medical Examiner must be notified at

Directo

Funeral

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with the Maryland

Baltimore, Maryland 21215-0036

physician and the burial-transit attending ph the neral Director:

Completed

Be

Certification: To

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

after

To the Hospital within 24 hours a To the Funeral I

completely

Box 68760

Records, P.O.

Division of Vital

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

Due to (or as a consequence of):

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown

24a. Was an autopsy 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 No

1 Yes 2 No 27. Manner of Death 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

25. Was case referred to medical

5 ☐Pending investigation

6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of (Month, Day, Year)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

I Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number 1154620540 29d. Date signed (Month, Day, Year) MAY 22,2012

of person who completed oduse of death (Item 23a) (Type, Print) JOY CHANG 22 S. GREENE ST BALTIMORE, MD 21201

31. Date filed Mp/s State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Myrtle Jean Krauss 9:03 2012 P^{M} Medical May 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Co. 1748 Tacoma Road Edgewater If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2XXF Hours 578-24-3222 Aprill 8 Day 1924 Virginia Director 88 Usual Residence of Decedent 28a-f show iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Edgewater Anne Arundel Maryland 1 🗌 Yes 2 🔀 No 10e. Street and Number 10g. Citizen of What Country? United States 21037 Funeral 1748 Tacoma Road death with of America 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Force Black, White, etc. þ 1 \square Never Married 2 \square Married . Page 1 and 2 should be filed within 72 hours after ument of Health and Mental Hydiene." natural", or smart if item 27 is marked other than "natural", or inny or other traumatic event, the Medical Examining to other traumatic event, the Medical Examining. Yes 2XXNo Maryland 21215-0036 1 Yes 2XXNo Specify: white If Yes, Give 3 🕅 Widowed 4 🗌 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Lumber Company 12 Be 18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Jean Leake

Gladys Hilleary 17. Father's Name (First, Middle, Last) ပ Thomas Leake 19a. Informant's Name/Relationship (Type, Print)

Karen Wilson/ daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6305 93rd Place Seabrook, Maryland 20706 6305 93rd Place Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 30. Department of Important: If it any injury or o Evans Funeral Air Chapel-Bel Air 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) Forest Hill, Maryland 2012 21. Signal of Ju eral Service License Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Between Immediate Cause (Final Phinician. disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to for as a consequence on Exami physician and s the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2XXNo Physician: The law requires that the death 5 Other (specify) Pregnant at time of death signed by the a 1 ☐ Yes 2X 9 ☐ Unknown 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Completed Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page performed? Yes XX No death? 2 46 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2**XX**No 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home XX Residence 6 Other (Specify Director: After this of in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending thin 24 hours after death. 5 Pending injury 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) 24 hours a Medical Certify as Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Extiminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the ilms, date and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title 29d. Date signed (Month, Day, Year) 4526981 19 to completed cause of death (Item 23a) (Type, Print) 30. Name and address of 31. Date filed (Month, Day, 32. Registra State 2012 Registrar

			For State Registrar	State of Ma	aryland	•		of Healtr of Death		lental Hy	giene	20	12	16	833
ı	Physicia	an/	1. Decedent's Name (First, Middle, Las	7			imouro	- 0, D 0 a		2. Date of De	ath		'ear	3. Time	of Death
	Medic Examir	cal	4a. Facility Name (if not institution, give	RICHIN street and number)	SKY		4b City 1	own, or Locatio	n of Death	MAY		25 20 c. County of	12	8.00	PM
)	Examil	lei	SEASONS HOSPICE @	NORTHWEST	r HOSP	ITAL		ANDALLS			40		LTIM	ORE	
	Funeral Director		5. Social Security Number 6. Security Number 1212-07-9493 1	ex 7. Age	(In yrs. last i		If Under Months	1 Year If Und Days Hours	er 24 Hrs. Min.	8. Date of Birl (Month, Da		9	Birthpl Counti		or Foreign
			Usual Residence of Decedent	LIW Z LAF	93	Yrs.				07/30,	/191	8		MD	
	iryland a-f sho ied at	Director	10a. State 10b. County MD BALTIM	(ODE	10c. City, To								10		City Limits es 2 X No
	or 28% e notifi		MD BALTIM 10e. Street and Number	IOKE	Б	ALTIN	10f. Zip	Code			10g. C	itizen of Wh	at Count		And
	h with	Funeral	1 POMONA WEST,					21208				USA			_
980	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Education Armed Forces? 1 Yes 2 II Yes, Give Year or Dates.	ver in U.S. No	II	Yes, speci	ent of Hispanic C fy Cuban, Mexic No Speci	an, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Black, Specify:	America White, e	tc.	
2-0	2 hour "natur edical	plete	15. Decedent's En (Specify only highest gra	ducation	1	6a. Deced	lent's Usual	Occupation done during me	ost of work	ina	16b. l	Kind of Busin			_
Maryland 21215-0036	ithin 7; ene. r than	Completed	Elementary/Secondary (0-12)	College (1-4 or 5-	+)	life. DO	O NOT use	retired)		9	ľ	FOOD	STOR	E	
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Baltimore,	ge 1 and it of Healt it of Healt or other		20a. Method of Disposition 1 X Burial 2 Cremation 3		20b. Place	e of Dispo	sition (Nam	e of		Date		ocation - Ci		vn, State	
Ţ.	permit. Page 1 Department of I Important: If it any injury or o'		4 Donation 5 Other (Specific	(y)	FORB		CEMETI			9/2012		ALTIM			
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)	hysician/ Medical Examiner	er	23a. Part 1. Enter the disease, or come shock, or heart fallure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (or as a	SCLE	ROT ce of):	i C	of dying, such a	as cardiac d	or respiratory and	rest,	R DI		Approxim Interval Be Onset and	
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/Ital	rsician; The s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	int 2 ED	/Outpatien	+ 3 🗆 🗅	26. Place of D		only one) ome 5 \square Resid	donoo	a Dothar (Spacifil	TPU	Hospico
on of \	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certification pletely filled in by the funeral director,	Certificate: T	27. Man of Death Natural 5 Pending 2 Accident Investigation	28a. Date of injur (Month, Day,	y 28	b. Time of injury		c. Injury at work?		28d. Describe h	iow inju	ry occurred	<u>зреспу),</u>	<i>y</i> , - ,	
DIVISI	ital or Atteurs after de ral Directo		3 Suicide 6 Could not be 4 Homicide determined	bullding, etc.	(Specify)					28f. Location (S City or Tow	ın, State	e) 			nber,
	e Hosp 24 ho e Fune eletely f	Medical	(Check 2 Medical Exami	sician: To the best of r iner: On the basis of ex se Practitioner: To the	amination an	d/or invest	igation, in m	y opinion, death	occurred at	the time, date a	nd place	e, and due to	the caus	se(s) and m	nanner stated.
	Vithir Comp	2	29b. Signature and title of certifier	<u> </u>	Boot of Hij K	,	29c.	License number	r			ate signed (A			
			Jasneer	Yalha	ui n	11)		12/19	5		5	126/1	2		
			30. Name and address of person who class NEEM A	completed cause of de	eath (Item 23.	a) (Type, P	Boy	1525	Owi	NGS 1	MILL	M) c	4117	
	Sta		31. Date filed (Month, Day, Year)	2. Registra	r's Signature		11		-						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#8perFH, G928, 6/6/2012, WS State of Maryland / Department of Health and Mental Hygiene 16834 For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month 5 Physician/ 2:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2643 Streamview Drive Anne Arundel Odenton 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Manth Ray, 14935)5 CoMaryland 214-66-3586 56 Director 1 M 2 D F Yrs Usual Residence of Dec 01-19-55 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director notified 1X Yes 2 □ No MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? must be Funeral 23a 2643 Streamview Drive 21113 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, ortant: If item 27 is marked other than "natural", or itel injury or other traumatic event, the Medical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify 3 Widowed 4X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed, 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Sales Executive Automotive 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Department of Health and Ment. Important: If item 27 is marked any injury or other. Louis LeRoy Kibler Kathryn Jean Jasper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kristen L. Fisher / Daughter 16301 Oxford Court, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 5/30/2012 Beltsville, MD Signature of Funeral Service I 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413, Baltimore, MD 21203 Lanto 23a. Part the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ STAGE CAR DIOVASCULAR disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): as the burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE: nse yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery ate has been signed by the atte page 2 should be detached for in the past 12 months? Month 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1010 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this e Hospital or Attending Pl 124 hours after death. e Funeral Director; After th Manner of Death 28a. Date of injury (Month, Day, Year, 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending iniury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Descrifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check To the within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) death (Item 23a (Type, Print) Name and address of person who SIL

Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day, Year)

2012

Box 68760

P.0.

Division of Vital Records,

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State o	f Maryland		artment d tificate d				giene Reg. No. (0010	1000
	nysicia		1. Decedent's Name (First, Middle, Michael	Last) Kels						2. Date of Dea Month	/	Year ZOIZ	3. Time of Death 3. 5 A M
	Medic kamin		4a. Facility Name (If not institution, Johns Hopkins Bay		,		Baltimo	ore	ation of Death			unty of Death	
Dire	eral ector		5. Social Security Number 220-52-4401 Usual Residence of Decedent	6. Sex 1 X M 2 □ F	7. Age (In yrs. las		If Under 1 Y Months D		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day 03/31/	; Year)	Count	lace (State or Foreign ry) yland
yland 21215-0036 Juld be filed within 72 hours after death with the Maryland Mental Hygiene. Mental Hygiene. Mental Hygiene.	must be notified at	Funeral Director	10a. State 10b. County MD Balt 10e. Street and Number 47 Mavista Avet 11. Marital Status	12. Was Dece	Dun	Town or Local Idalk	10f. Zip-Co	22 of Hispar	nic Origin? (Spe	cify Yes or No-	U.	of What Coun	an Indian,
21215-0036 ad within 72 hours after giene. er than "natural", or ite	e Medical Examiner	Completed by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent' (Specify only highest Elementary/Secondary (0-12)	If Yes, Give Year or Date of Section 1985	2 XNo e ites:	16a. Decec (Give life, L	dent's Usual Okind of work doo NOT use re	No Speccupation	lexican, Puerto f pecify: g most of workin		Sp. 16b. Kind	of Business/Inc	nite
Maryland 2: 2 should be filed very and Mental Hygie is marked other to	matic event, th	To Be Co	12 17. Father's Name (First, Middle, Le James A. Ke 19a. Informant's Name/Relationshi	els			ainter ng Address (Si	7	Mother's Name Virginia Number or Rura	а М.	Maiden Su Noy	es	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show	any injury or other trau		Patricia Kels 20a. Method of Disposition 1 Burial 2 Cremation 4 X Donation 5 Other (Sp. 21. Signature of Fuheral	3 ☐ Removal from Secify)	State cer	nce of Dispo metery, cren atomy G	sition (Name on natory or other ifts Reg 2. Name and A	of place) istry ddress of	05/2! Facility Ana	ate 5/2012 atomy G	20c. Locat Hano ifts	ver, Ma Registr	ryland
Physic /Med Exami	cian ical	ler	23a. Part 1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	aa. Due to (ch line. Julia or as a conseque	Do not enter	er the mode of	f dying, su					Approximate Interval Between Onset and Death
I Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and	is the burial-transit	ledical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseque	ence of):							
P.O. Box 68 nat the death certific by the attending p	etached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b 4 ☐ Pregn 9 ☐ Unkno		death 3 th	Ectopic pregi	y)	Park I	00 - Pid		d. Date of delive	Day Year
Records, ne law requires th has been signed	ige 2 should be d	Completed by	Part II. Other significant condition	as contributing to de		Tail	1	se given i	n Pan I.	1 🗆 Y 24a. Was a autop perfor	res 2 🗆 1 in 2 sy med?	No 3 Prob 24b. Were auto prior to co death?	psy findings available mpletion of cause of
Division of Vital Records, to the Hospital or Attending Physician: The law requires th within 24 hours after clearh. To the Funeral Director: After this certificate has been signe	ector,	Certification: To Be Co	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate investigate 3 Suicide 6 Could not determine	28a. Date of (Month) ation of be 28e. Place		R/Outpatien 28b. Time of Injury ne, farm, stre	f 28c.	Other: 4 Injury at Work? 1 Yes	2 🗌 No	ne 5 Resid	ence 6 ow injury o	ccurred	
To the Hospital within 24 hours of To the Funeral I	ompletely filled	Medical Co	29a. Certifier (check only one) 1 ★Certifying 2 □ Medical E	Physician: To the Examiner: On the ba and man	asis of examinatio	edge, death on and/or in	vestigation, in	he time, d my opinio cense nun	on, death occurr	ed at the time,	date and p	nd manner as s lace, and due t igned (Month,	o the cause(s)
d se	٥		30. Name and address of person v		se of death (Item :			006	,9427 4040 F		May	12 70	17
RODHMH 17.5	Sta egistra	ar	Dr. Kiemanh Pha 31. Date filed (Month, Day, Year) • MAY 30		gittrar's Signatur	1. 4.	ald		4940 E8	ISIEFFI AV	enue,	baitimol	e, MD, 21224

Registrar DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 4a-c. 26 per doc g927 5-30-12 vt. State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death KUNDA Month 05 Physician/ Year EEL 12: 25 AM Medical 4a. Facility Name (if not institution, give street and number)

4993 Brampton Pkwy 4b. City Tawn or Location of Deat 4c. County of Death **Examiner** Social Security Number 7. Age (In yrs. last birthday) Year If Unde 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Director 115-26-7203 1 M 2 XF 09 New York 23a or 28a-f show 10b. County aţ 10c. City, Town or Location Director Examiner must be notified 1 🔀 Yes 2 🗌 No DE Sussex Lewes 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? by Funeral 19958 U.S.A. 23593 Mallard Lane and Mental Hygiene. is marked other than "natural", or items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Black, White, etc. Yes 2X No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes. Give 3 Divorced 4 Divorced White Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Department of Health and Ment, Important: If item 27 is marked any injury or other. Elizabeth Maloney Charles Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Kunda / Spouse 23593 Mallard Lane, Lewes, DE 19958 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1
Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 X Donation 5 Other (Specify) Anatomy Gifts Registry 05/18/2012 Hanover, Maryland 21. Signature of Fineral Service Licen Anatomy Gifts Registry 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between nset and Death Immediate Cause (Final Ph_sician/ Static disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence off Exami the Hospital or Attending Physician; The law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of) resulting in death) Last physician s the buria Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery for 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) 2 🔼 No ed by the a 9 Unknown signed by tall Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performed? Yes 2 N 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: daughter's 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.
Funeral Director: After this stely filled in by the funeral o residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier 1-X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Configuration Number Fractilities or To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Configuration Number Fractilities or To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Configuration Number Fractilities or To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Configuration Number Fractilities or To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Configuration Number Fractilities or To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Configuration Number Fractilities or To the basis of examination and/or investigation, in my opinion of the cause of t 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOOL6 129 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. BROADWAY, BALTIMORE, MD ANTONARAKIS EMMANUEL 461 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 27,^D2012 Μ'n 4:05 aM PAULINE CECILIA KNIGHT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A 930 S. CONKLING BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth (Month, Day, Year)
ULY 13,1925 Months Davs Hours Director 212-20-6844 MARYLAND JULY 86 Usual Residence of Decedent or then "neturel", or items 23e or 28e-f sho 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 72 hours after death with the Maryland Director BALTIMORE 1 X Yes 2 No N/A 10e. Street and Number 10g, Citizen of What Country? Funeral 930 S. CONKLING STREET 21224 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black, White, etc. δ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes XIX No Specify: Completed Specify: 3 X Widowed 4 Divorced WHITE 21215-00 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOUSEWIFE DOMESTIC 8 Be laryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked 8 FITZGERALD GRILL EVA WILLIAM LAWRENCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a importent: If item 27 is eny injury or other trei 3506 O'DONNELL STREET, BALTO., MD. 21224 DARLEEN SCHNEIDER/DAUGHTER timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) BAYVIEW CREMATORY: 5/31/12 BALTIMORE, MARYLAND Signature of Service Licenses 22 Name and Address of Facility
LILLY & ZEILER
700 S. CONKLING INC. FUNERAL HOME STREET, BALTO., MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SND STA Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical use as the attending property for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes) No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; I 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and titl of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 25 Day 20^{Year} May William H. Krautler, JR 10:28 PMMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Dove House Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Director 719-01-3032 1 🔀 M 2 □ F 97 12/17/1914 GA f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No MD Carroll Woodbine 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 21797 7031 Woodbine Rd. USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🄀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 XWidowed 4 Divorced White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Il Hygiene. other than " U.S. Naval Elementary/Secondary (0-12) College (1-4 or 5+) Planner/Estimator/Machinist Ordnance Lab Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental I မ William H. Krautler, Sr. Edith Gladys Metcalfe and is 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 2202 Dennings Rd., New Windsor, MD 21776 Diane Ashelford/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o 1¥¥Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Morgan Chapel Cemetery 5/30/2012 Woodbine, MD of Funeral Service Licens ²² Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A. - any 1212 W. Old Liberty Rd., Winfield, MD 21784 a. Part Enter the disease, or complication hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death k, or heart failure. List only one cau FAILURE Immediate Cause (Final Physician/ dise e or condition re ting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence on Exami Cause (Disease or injury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Pregnant at time of death 5 Other (specify) g Unknown detached the Hospital or Attending Physician: The law requires that the 24 hours after death.
 Funeral Director: After this certificate has been signed by th signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(2 \sum \) No 24a. Was an autopsy page 2 this certificate funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: မ 1 Tyes 2 🛂 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? _1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred injurv Natural 5 Pending Accident Investigation completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one 29b. Signatu 29d. Date signed (Month, Day, Year)

State Registrar pleted cause of death (Item 23a) (Type, Print)

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16839 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 23:35M Medical Facility Name (if not institution, give street and number Examiner n, or Location of Death 4c. County of Death Hopkins ohns tospita timore N/A Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 219-42-9301 Months (Month, Day, Year) Days Hours Min. Director 1 🗆 M 2 🖰 F 66 Maryland 9/9/1945 Usual Residence of Decedent within 72 hours efter death with the Maryland 10b. County ir then "neturel", or items 23e or 28e-f sho the Wedical Exeminer must be notified at 10c. City, Town or Location Directo 10d. Inside City Limits Maryland Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 U.S.A. 1199 Ridervale Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ě Maryland 21215-0036 ☐ Yes 2 🔀 No 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 ★ Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 tel Hyglene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Mary Kraft Staffing College (1-4 or 5+) President /CEO t. Pege 1 end 2 should be filed wit trment of Health end Mentel Hyglei rtent: If Item 27 is marked other jury or other treumetic event, In 12 and HR Solutions Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leo Novak Mildred Pittard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kraft James / Son Baltimore, <u>1848 Laurel Ridge Drive</u> Parkton, Maryland 21120 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State permit. Pege Department of Importent: if eny injury or 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Serv. Corp. Towson, Maryland 5/31/2012 Signature of Ineral Service Licens 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami ettending physicien end I for use es the buriel-trensit or Attending Physicien: The lew requires thet the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physiclan/Medicai Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year cete has been signed by the page 2 should be deteched 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy
performed

1 Yes 2 No certificete 1 ☐ Yes 2 ☐ No completely filled in by the funerel director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes Other: |요 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending e Hospitel or Attendin 124 hours after death. e Funerel Director: Aft work? 1 ☐ Yes 2 ☐ No Investigation М 3 Suicide
4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EVAN 1800 Or 1PSON ean 31. Date filed (Month, Day, Year) State gistrar's Signature Registrar DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 28 SAIMA KHATOON 1407 M MAY 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Dea Battimore washington Medical DUTNIE ANNE 2N Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 1 □ M 2 🗹 F -1938 LNOUG 28a-f show 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No evern 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral Z NO St 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. "natural", or 1 Never Married 2 Married ģ 2 No 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify Completed 3 Widowed 4 Divorced SIW Year or Dates permit. Page 1 and 2 should be filed within 72 hour postartent of health and Mental Hyglene. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) tousewi OMIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) tussau N Labu NNISA 19a. Informant's Name/Relationship (Type, Pript) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) dentine 7817 SON Nalem Ur. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 9-2012 4 ☐ Donation 5 ☐ Other (Specify) and 21. Signature of Funeral Service Licensee 1-Willian essup 10220 MI23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death

5 YEARS Immediate Cause (Final Physician/ HYPERTENSION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Dav Year Pregnant at time of death Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by ASTHMA 1 Yes 2 No 3 Probably 4 Unknown Completed PULMONARY FIBRUSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 ☐ Inpatient 2 🗹 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending iniury work? 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) S. Chandry D55113 MD MAY 2012 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

SAJIDA

31. Date filed (Month, Day, Year)

CHAUDRY

ANNAPULIS

RD

COENTON

21113

MD

1132

. Registrar's Signature

Physician/ Medical **Examiner Funeral** Director 28a-f show must be notified at Director 9 or items 23a Funeral within 72 hours after death the Medical Examiner þ Baltimore, Maryland 21215-0036 "natural" Completed permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Manay injury or other traumatic event the Manay injury or other traumatic event the Manay injury or other traumatic Be

attending physician Box P.0. á Records, or Attending Physician: The law Division of Vital After this death. To the Hospital or Attend within 24 hours after deatl To the Funeral Director.

RICHARD

THUNKY

AWRENC

1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 02.45PM Month 2012 Henry Richard Lawrence 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TALBOT HOSPITAL EASTON MEMORIAL . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min (Month, Day, Year, 063-14-2919 1 X M 2 🗆 F New Jersey 91 Nov 21, Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits MD Queen Annes Queenstown 1 ☐ Yes 2x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 128 Greenwood Creek Road 21658 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify. Specify: 3 Divorced 4 Divorced **'**42**-**45 white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ engineer manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Henry Merrick Lawrence Anne Elizabeth Schulke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Lawrence/spouse 128 Greenwood Creek Road Queenstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Si atu of lune 18 Ronald 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimroe Street
Baltimore, MD 21201 Director art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or contion resulting in death) Physician/ SEPSIS Medical Due to (or as a consequence of): Examiner HOURS PNEUMONIA ASPIRATION Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 🗌 No Yes 2 No 1 Tes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier сотретел (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 00 66441 2012 MAY 23 Eramitor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2195 WASHINGTON ST , EASTON , MD Kolli, Ramesh 31. Date filed (Month, Day, Year) State bares Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 9 per fh g950 4-21-14 vt. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 Per PHY G9286/20/2012 JH State of Maryland Department of Health and Mental Hygiene 1 - For State Registral 16842 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 280ay Year Month **Physician** Anne, B, Lynch
4a. Facility Name (If not institution, give street and number) 0600 AM Mar 2012 /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore (offons wille Frederick Villa Norsing Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 177-26-5173 12/7/1933 Director Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland
10e. Street and I 1 ☐ Yes 2 No Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. I important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Exemple must be any Injury or other traumatic event, the Medical Exemple must be appear. 21228 711 Academy Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No If Yes Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: white þ 3 ☐ Widowed 4 🏋 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Wehrle Madeline McGovern ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kevin Lynch / son 2402 Pelham Avenue Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 5/30/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Fune al Service LicenseeStephanie Custer 22. Name and Address of Facility Cremation Society of Maryland Inc 35 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Offerioscleratic cardiovacular disease 3 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral <u>Directors</u> After this certificate has been signed by the attending physician and reley filled in by the funeral director, page 2 should be detached for use as the buriat-transit Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 5-29-2012 round Friend CRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road, Catonsville, MD 21228 Acadena haria Friend 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

MAY 3 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 25, Physician/ 2012 2:23 AMLove Donald Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lothian 6340 Mallard Lane Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) . Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** 354-26-3651 1 1 M 2 | F **Director** Aug. 23, 1935 76 **Illinois** Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No |Maryland | Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20711 6340 Mallard Lane U.S.A. and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White If Yes, Give 3 → Widowed 4 □ Divorced Completed Year or Dates and Mental Hygiene.
is marked other than "natur aumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Finance Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mae Lydon David Love injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6340 Mallard La., Lothian, MD 20711 f Health aitem 27 Erin Love (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 Department of Important: If it any injury or o cemetery, crematory or other place)
Dodson Branch X Durial 2 Cremation 3 Removal from State 5/30/2012 Gainesboro, TN Donation 5 Other (Specify) 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine Street, Alexandria, ature of uneral Service Mun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pas Kmsons Discose Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): the burial-transi requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ i signed by the atten Id be detached for u in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 Yes 2 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 124 hours after death.

Per Funeral Director, After this certificate has been signed to the page 2 should 1 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 X Natural 5 Pending iniury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 125/20/2 DO052089

State

DHMH 17 Rev 06-2011

Registrar

BUVD +300

32. Registrar's Signature

GAMBRILLS

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRAWDERMIL

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month ()5 2012 Physician/ 2:40 Рм Beatrice Levenstein Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Gilchrist Hospice Center Columbia Columbia 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days (Month, Day 1482)7 New York 076-22-5081 85 **Director** 1 🗆 M 2 🗀 Usual Residence of Deceder 10d. Inside City Limits show 10a. State 10c. City, Town or Location must be notified at Director Yes 2 No 28a-f Howard Columbia MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö Funeral ural", or items 23a Examiner must b 21044 7110 Minstrel Way USA permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 No Black, White, etc 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify If Yes, Give 3X Widowed 4 □ Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Electrical Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ပ္ Solomon Brownstein Regina Rittberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Susan Lerner / Daughter 2319 Bermondsey Drive, Mitchellville, MD 20721 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 5/29/2012 Chesapeake Crematory Beltsville, MD Signature of Funeral Service License 22. Name and Address of Facility once Maryland Cremation Services, PO Box 1413, Baltimore, MD 21203 evanita 23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 performed? Yes 2 No 1 Yes 2 No 1 Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) မ 1 🗌 Yes 2 **M** No 1 Inpatient 2 ER/Outpatient 3 DOA this Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury 1 Yes 2 \square No Accident Investigation within 24 hours after death

To the Funeral Director: A

completely filled in by the 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) MAY 25, 2012 D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

State Registrar 6336

DOBERMAN, MO

32. Registras Signa

CEDAR LANE COLUMBIA, MS 21044

12-03991 James Lincoln		Please Type or Print in Black Indelible Ink. Ensure All Copi State of Maryland / Department of Health and Mental I		
James Emoon		1- For State Certificate of Death	Reg. No.	2 1684
Physici		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year	3. Time of Death
Medical Exami	ner	James Lincoln	May 26, 2012	1050 hrs
" must be "		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea 1623 Gorsuch Avenue Baltimore	th 4c. County of Dea	tn
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hi		
Director		217-52-5463 1 M 2 F (02 Yrs. Months Days Hours Mi	in. 6/28/1949 Fore	ign ountry) S, C.
	П	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
ow any				1 Yes 2 No
Maryland 28a-f show d at once.	Director	MD N/A BAHmore 10e. Street and Number 10f. Zip Code	10g. Citizen of What Cou	_
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Heath and Mental Hygiene. nnt: If item 27 is marked other than "natural", ar items 23a or 28a-f shour mits fritum 27 is marked other than "natural", ar items 43a or 28a-f shour makes traumatic event, the Medical Examiner must be notified at once.	E I	1423 Gorsuch Ave. 21218	USA	
h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S		rican Indian, Black,
or deat	튑	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		lack
136 thin 72 hours after than "natural", edical Examiner	ğ	15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of	1 , 10-1	
6 1 72 hou an "na cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	etired)	
5-0036 led within 7 Hygiene. other than	Ē	12th N/A Plumber	1,11011	lorker
215-00 be filed with ntal Hygien rked other ent, the Me	Bec		ne (First, Middle, Maiden Surname) Beulah Brunson	
ID 21215-00; should be filed with and Mental Hygiene 7 is marked other timatic event, the Med	10 B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or		e, Zip Code)
MD 2 d 2 shou lth and N n 27 is n		La Marrien Lincoln-Wife 11623 Gorsnich Ave. 15	Salto, MO 21202	
imore, ML Pages I and 2 s nent of Health an ant: Witem 27 nr nther traum	П	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c, Location - City of	r Town, State
time trant		4 Donation 5 Other Specify: King Memorial PK. 61	1/2012 Kandallsto	own Mo
Baltimore permit. Pages I Department of F Important: If injury nr nther		21. Signature of Funeral Service Licensee 22. Name and Address of Facility MG	arch-MHEast 1101 t	= North Ave.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyin it, such as cardiac failure. List only one cause on each line.	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease		Death Death
		or condition resulting in death) Due to (or as a consequence of):		
	ē	if any, leading to immediate Due to (or as a consequence of):		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):		
executed an and al - transit	Cal Ey	d		
D, be exe sician a		UNPENDED #18perFH.G927.5/30/2012.WS		
876(ifficate ig phy	M/U	IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnance	23d. Date of deliver	y Day Year
ox 6 ath cert	sicia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		
Records, P.O. Box 68760, The law requires that the death certificate be icate has been signed by the attending physicipage 2 should be detached for use as the built	Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that tr after death. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.		Prostate Cancer	1 Yes 2 No 3 Prol	bably 4 🗹 Unknown
rds requir	Completed by			topsy findings available completion of cause of
he law	E		performed? death? 1 Yes 2 ✓ No 1 Yes	
inn: 7	B B	25. Was case referred to medical examiner?		
F Vid	eL	1 Yes 2 No No Inpatient 2 ER/Outpatient 3 DOA VIOLET Nursin	ing Home 5 Residence 6 Other	r: Scene
on on on on the function of th	ë	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	25d. Describe flow injury occurred	
r Attend r Attend ter death. irector: n by the	ficat	2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Ru	ral Route Number, City
Dival o	Certification:	4 Homicide determined (Specify)	or Town, State)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation_in my opinion, death occurred		
To the within To the comple	ᄝ	one) 2 Medical Examiner: On the basis of examination and/or investigation arr my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Mo.	
		O.C.M.E.	May 27, 2012	. = -,,,
330	-	30. Name and address of person who completed cause of death (Item 23a)		
9		Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltin	more, MD 21223	
Sta Regist	ate	31. Date filed (Month, Day Year) NAY 3 0 2012 Lenux 32. Regignar's Signature A. Faule		
ricgiat	المنتد	THE COURT TO STATE OF THE STATE	: CA .	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4b. City, Town, or Location of Death (If not institution, give 4c. County of Death Examiner Johns Hopkins Bayview Medical Center N/A**Baltimore** 8. Date of Birth (Month, Day, Year) 11/17/1927 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🛣 F MARYLAND 218-22-4096 84 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show must be notified at 1 XYes 2 ☐ No Director BALTIMORE N/A 28a-f MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code Items 23a or 21224 U.S.A. 402 N. LINWOOD AVENUE Funeral death v 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status "natural", or Iten edical Examiner r Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: by If Yes Give Specify: WHITE 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation event, the Medical 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) DOMESTIC 8 HOUSEWIFE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked ot Be WARIEWSKA JAGODZINSKI MICHALINA NICHOLAS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 N. LINWOOD AVENUE, BALTIMORE, MD 21224 item 27 CARMELLA LANE/DAUGHTER other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Department of F
Important: If ite
any Injury or ott 1 XBurial 2 Cremation 3 Removal from State GARRISON FOREST V.A. 6/5/12OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME
1901 EASTERN AVENUE, BALTIMORE, MD 21. Signature of Funeral Source Licensee 21231 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ech line Immediate Cause (Final Physician disease or condition /Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 honths? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached for P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Tes 2X No 3 Probably 4 Unknown certificate has been sig lirector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performe 1 🗌 Yes 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 □ No 26. Place of Death (Check only one) funeral director, Be Hospital: 1 \square Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA ည this 28d. Describe how injury occurred 27. Man ir of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: After 1 X Natural 5 Pending investigation Injury 1 Yes 2 No death. within 24 hours after death

To the Funeral Director: A
completely filled in by the i 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) Metical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manne stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, death (Item 23a) (Type, Print) 30. Name and address of

DHMH 17 Rev 1/2001

State

Registrar

30

2012

4940 Eastern Avenue, Baltimore, MD, 21224

12-03900 Catherine Cecilia	ı Lie	Please Type or Print in Black Indelible Ink. Ensure the Black	e All Copie d Mental Hy	s Are Lo	egible		2 1684
		1- For State Certificate of Death			Reg. No.	201	2 1004
Physicia Medical Examin	ın/	1. Decedent's Name (First, Middle,Last) Catherine C. Liebknecht		2. Date of De Month May 22,	Day	Year	3. Time of Death 1009 hrs
			Location of Death			c. County of Deati	1
		4242 Roop Road Mount Airy			(Carroll	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea Months Day:			3irth(MM 1/19	/DD/YYYY) 9. Bir Foreig	
	ŀ	Usual Residence of Decedent					
w any		10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits 1 Yes 2 XXNo
ith the Maryland 23a or 28a-f show i	5	MD Carrol1 Mt. Airy 10e Street and Number 10f. Zip Code			10= Ci4	izen of What Cou	
Mary: Mary	Director				rog. Cit		nu y r
ith the		4242 Roop Rd. 217 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His		ecify Yes or I	No-	USA 14 Race - Amer	ican Indian, Black,
ath wi	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cubar			•	White, etc.	real frederi, Diacot,
ter de		1 Yes 2 X No 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2XX No	specify:			Specify: Wh	ite
2 hours afte "natural", Examine:	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupat			16b.	Kind of Business/	Industry
on "72 ho	ete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life					
5-0036 iled within 77 Hygiene. I other than	Completed	12 Administrativ			11	Ecolab	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ant of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", nr items 23a or 28a-f she nr other traumatic event, the Medical Examiner must be notified at once		The state of the s	18.Mother's Name			Surname)	
2121 Ould be fi marked ic event,	To Be	Richard Liebknecht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stree		n Eski Rural Route N		ity or Town, State	, Zip Code)
Z shou and I ard I		Roslyn Gilligan/Mother 4242 Roop R	Rd. Mt.	Airy,	MD 2	1771	
e, N l and l Health	1	20a. Method of Disposition 20b. Place of Disposition (Name of cer		Date		Location - City or	Town, State
MOFe, Pages 1 au tent of He int: If ite		1 X Burial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify: Druid Ridge Cemet	ery 5/2	6/2012	l P	ikesvill	e. MD
Baltimore, ME permit. Pages 1 and 2 s Department of Health a Important: Witem 27 injury or nuber traum.	Ì	21. Signature of Funeral Service Inchese 22. Name and Address Burrler					
iii iii Deg	ŀ	1 1212 W. C	old Liber	tv Rd.	. Wi	nfield,	MD 21784
Physician		22a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, failure. List only one cause on each line.	, such as cardiac o	r respiratory a	arrest, sh	ock, or heart	Approximate Interval Between Onset and
Medical Examiner	İ	Im edi e Cause (Final disease a Narcotic (Methadone) Intoxic	ation				Death
- ' '		or condition resulting in death) Due to (or as a consequence of):					
	5	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
	Examiner	C. Due to (or as a consequence of):					
and and transit		events resulting in death) Last Due to (or as a consequence or): d.					
	lical	▼ UNPENDED	28 6-19-1	2 sm			
Box 68760, e death certificate be ex the attending physician red for use as the burial	an/Medic	IF FEMALE: 23c. If yes, outcome of pregnancy			23	d. Date of deliver	,
Box 68760, e death certificate bo the attending physiced for use as the bur	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 Other (Specify)	Ectopic pregna	ncy		Month I	Day Year
Sox leath of e atter for u	Physici	1 Yes 2 No 9 V Unknown 4 Pregnant at time of death 5 Other (Specify)	-				
O. E at the at the tached	된	Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	given in Part I.				the cause of death?
Division of Vital Records, P.O. at or Attending Physician: The law requires that the staff cleath. al Director: After this certificate has been signed by led in by the fineral director, page 2 should be detach	d by	·		1Y	es 2	No 3 Proi	oably 4 🗸 Unknown
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ecc he lav ate ha	Completed			per 1 ✓ Yes	formed?	death?	es 2 No
1 of Vital Recting Physician: The l After this certificate funeral director, page	Be		e of Death (Check	only one)			
Vita hysici this o		1 Yes 2 No				ence 6 🗸 Othe	r: Scene
1 Of ling P		(Month, Day,Year)	ıry at Work? Yes 2 🕱 No	28d. Describ unknow	•	ury occurred	
SiOr Vittend death ctor:	catic	2 Accident Investigation fd 5-22-12 fd 10:05 am				and Number of Pu	ıral Route Number, City
Nor A after A Dire	ertification:	3 Suicide 6 X Could not be determined (Specify) Residence		or Town	State)4	242 Roop	
lospita hours uners	O	29a. Certifier		Mount due to the ca		-	ed.
Division of Vital Records, P.O. Box 68760, The Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours state death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion	n, death occurred a	t the time, da	te and pla	ace, and due to th	e cause(s)
To with	¥.	and manner stated. 29b. Signature and title of certifier 29c. Licens	se number		29d.	Date signed (Mo	nth, Day, Year)
		Thetall King TR) O.C.	M.E. OGNE		Ma	y 23, 2012	
4	ŀ	30. Name and address of person who completed cause of death (Item 23a)					
P		Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltin	nore Street, B	altimore, N	/ID 212	23	
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LOHIN 5KI Physician/ GERARD Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice at Northwest Hospital Raltimore Randallstown Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) Director 219-32-9060 **XX**M 2 ... F 74 11/04/1937 Maryland Usual Residence of Decede 23a or 28a-f show 10b. Count 10c. City, Town or Location with the Maryland Examiner must be notified at 10d. Inside City Limits Funeral Director Maryland Baltimore Pikesville 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6824 Parsons Avenue 21207 United States permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinar man 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married 21215-0036 If Yes, Give Year or Dates. 1958–60 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Payroll Supervisor Insurance Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Lohinski Anna Imbierowicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Lohinski - Wife 6824 Parsons Avenue Pikesville, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 😾 Burial 2 🗀 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Holy Rosary Cemetery 05/26/2012 Baltimore, Maryland Signalare | f Funeral Service Lic David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 Enter the disease, or complicate ock, or heart failure. List only one ca ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year signed by the ai Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 D 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 1 No Other: ျ After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 28a. Date of injury (Month, Day, Year) 27. Manne Death e Hospital or Attending Pi 24 hours after death. e Funeral Director: After ti 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred U atural 5 Pending Accident 1 Tes 2 🗌 No Investigation 6 Could not be ... Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

State

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Sherman Lester	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2012 1684
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director	235022909 1 M 2 F 5 I Yrs. Months Days Hours Min. 11/04/1960 Foreign Country) WV
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
-f show	Baltmore 1 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
with the Maryland 11 23a or 28a-f sho be notified at once stal Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
r death with or items 23 must be no Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be autified at once ted by Funeral Director	3 Widowed 4 Divorced of Pales: 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No specify: Specify: White
"natura Exami	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
5-0036 led within 72 hour Hygiene. I other than "natu the Medical Exan Completed	Janitor Janitorial
三 三 三 三 二	17. Father's Name (First, Middle, Last) Kenneth Carl Lester Norma Jean Ali FF
2 B M E S C	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224
Magarith 2	Patricia Lester doughter 4014 Fennington Hve Batto MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Cardina Company Compan
Baltimore ermit. Pages 1 a Department of He Important: If it injury or other t	4 Donation 5 Other Specify: TIAM 5/85/18 JESSUP PA
Baltimo permit. Page Department of Important: injury or oth	21. Signature of Fun of Service Livensee 22. Name and Address of Facility Avec F H 270 Freeholder Possis
Physician	23a. Part f. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):
<u>~</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
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60, tte be execut hysician and e burial - tra	TE ESMALE: 23c If yes outcome of pregnancy 23d Date of delivery
Box 68760, c death certificate be the attending physic of for use as the burnhysician/Med	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (Specify)
b. Box 6876 the death certificate by the attending pheched for use as the	1 Yes 2 No 9 Unknown 9 Unknown Part B. Other stantificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
P.C es that gened let deta	1 Yes 2 No 3 Probably 4 V Unknown
Division of Vital Records, talor Attending Physician: The law requires rs after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed	24a. Was an autopsy findings available prior to completion of cause of
Reco	performed? 1 Ves 2 No 1 Ves 2 No
F Vital Physician: rr this certi ral director	25. Was case referred to medical examiner? 1 V Yes 2 No
n of Niding Ph. h. After t' e funeral	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No
Division o spital or Attending to the shift of the shift	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Divis lospital or At hours after d uneral Direct ly filled in by	4 Homicide (Specify) 29a. Certifier 1 Certifier Physician. To the host of my knowledge death occurred at the time date and place and due to the cause(s) and manner as stated
To the Hospital within 24 hours To the Funeral completely fille	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
The state of the s	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 25, 2012
	30. Name and address of person who completed cause of death (Item 23a)
State	Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year)
Registra	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Michael Edward Livers Month 05 13:12 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death N/A Union Memorial Baltimore 5 Social Security Number 217-56-5220 . Age (In vrs. last birthday If Under 1 Year I If Under 24 Hrs. 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Hours Director 1 ▲M 2 □ F 04/09/1952 60 Maryland or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore ¹X Yes 2 ☐ No the 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 5527 Cadillac Ave. Apt 1 21207 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Kes 2 No Black, White, etc. ge 1 and 2 should be filed within 72 hours after c it of Health and Mental Hygiene. If item 27 is marked other than "natural", or i þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates Yes 2 XNo Specify 3 Widowed 4 N Divorced Specify: Black Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) 1 2 th tan Grade (0-12) College (1-4 or 5+) Laborer Chimes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Theodore E. Livers Ethel Stokes other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Livers(daughter) 5527 Cadillac Ave. Apt 1, Balto., MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 1 Burial 2 Kremation 3 Removal from State injury or Department Important; I any injury or once, on-site Crematory 5-/6-/2 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) re of Euneral Service Licensee Signatu JOSEPHAGAS OF BETOWN Jr. Funeral Home PA Class 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, in each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be Box 68760 as the l attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year ed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown P.O. I signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Hospital or Attending Physician: The law page 2 this certificate has autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No Other: 1 🗌 Yes ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending work' 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 24 hours after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MD 2012 ho completed cause of death (Item 23a) (Type, Print) Parkwar University

DHMH 17 Rev 06-2011

State

Registrar

. Date filed (Month, Day, Year)

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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		21. Signature of R			ettor	. 22	Name and	Address	of Facility	koar	d 655 1	J R	21+1	moro	Stro	o t	
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C	Medical Examiner		disease or condition resulting in death)	on .	a. Due to (or as	a consequ	uence of):			<u></u>	7							
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Ω	To the Hospital or Attending Physician: "Or thin 24 hours after deats after death "Or the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 (Check 2	Certifying Pl	nysician: To the best of miner: On the basis of o	f my knowl	edge, death o	occurred at the	e time,	date and	place, an	d due to the d	ause(s)	and manr	ner as sta	ted.	d manna	ar stated
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	State of Maryland /	Department of He	alth and Menta	al Hygiene

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		1- For State Certificate of De Registrar	eath		eg. No.	2 10036
Physicial	n/	Decedent's Name (First, Middle,Last)		2. Date of Dea Month	Day Year	3. Time of Death 0630 hrs
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Funeral			Under 1 Year If Under 24Hr Ionths Days Hours Mi) Fore	irthplace (State or
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A	_	Maryland Prince Georges Greenbelt				1 Yes 2 No
Maryland 28a-f show d at once.	탏	10e. Street and Number 10f	f. Zip Code		0g. Citizen of What Co	untry?
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ID 21215-00; should be filed with and Mental Hygiene I? is marked other.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add	dress (Street and Number or			
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Baltimore, MD 2 semit. Pages I and 2 shoul Department of Health and N important: If item 27 is in injury or other traumatic	İ	1 Burial 2 Cremation 3 Removal from State crematory or other p	lace)	25/2012	Baltimore	Maryland
Baltimore permit. Pages 1 Department of H Important: If i	ŀ	4 Donation 5 Other Specify: Metro Crema 21 Signature of Funeral Service LicenseeStephanie Custer 22. Name				
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Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the me failure. List only one cause on each line.	ode of dying, such as cardiac	or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and
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587(ertifica ling ph			eath 3 Ectopic pregr	nancy	Month	Day Year
Box 687 e death certifica the attending p ed for use as th	Physician/	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other ((Specify)		1	
that the doned by the detached is			lying cause given in Part I.		obacco use contribute to	
Division of Vital Records, P.O. ra or Attending Physician: The law requires that it rs after death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	d by				s 2 No 3 Pro	
ords w requ ts been should	Completed		<u> </u>	24a. Was auto	psy prior to	utopsy findings available completion of cause of
Recc The lav	E				ormed? death? 2 No 1	
Vital Rec ysician: The his certificate director, page	å	examiner? [Hospital:	26.Place of Death (Check		Residence 6 Oth	
of Viing Physi	은	1 V Yes 2 No		ing Home 5 28d. Describe	how injury occurred	ei
Vision of ' or Attending Ph fler death. Director: After t in by the funeral	틽	1 🗷 Natural 5 Pending (Month, Day, Year)	1 Yes 2 No			
visi or Att after de Direct in by	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, far	ctory, office building, etc.	28f. Location (or Town,		tural Route Number, City
Dj.	9	4 Homicide determined (Specify) 29a. Certifier 4 Control of Physician Tatta has a few keeping does does here with the part of				
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a one) 2 Medical Examiner: On the basis of examination and/or investigation,	at the time, date and place, ar in my opinion, death occurred	nd due to the cau lat the time, date	se(s) and manner as sta and place, and due to	ared. the cause(s)
To Witi	¥	and manner stated. 29b. Signature and title of certifier	29c, License number		29d. Date signed (M	
W.		The day Us hier The me. A.	O.C.M.E. 00	ME	May 21, 2012	
Whole		30. Name and address of person who completed dause of death (Item 23a)	NA/ Dalkimona Character	Daltimar- Pf	D 21222	
9		Theodore M. King, Jr., MD. Assistant Medical Examiner 900 31. Date filed (Month, Day, Year) 32. Registrar's Signature	vv. Baitimore Street,	Dailimore, M	D 21223	
Sta Registi		4 MAY 0 0 7010 6 4 4 4 4				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per FH G927 5/30/2012 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 22ª3 20**1**2 2:55 Evelyn S. Mackey p. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Joseph Richev Hopsice **Baltimore** n/a 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours Min (Month, Day, Year) 68 Director 212-42-5724 1 □ M 2X F Vrs 3-7-1944 MD Usual Residence of Decede show 10a. State 10b. County 10c. City. Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 ☐ No n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2519 Ridgely Street 21230 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Statu 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 ☐ Widowed 4 ☐ Divorced SpecifAfrican-American Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Cashier MerrittOil Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Nichols Evelyn Savov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard Mackey/ Husband 2519 Ridgely Street, Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Carrison Forest Veterans 6-6-12 Owings Mills, MD Signature Funer Service Lic ame and Address of Facility Wlie Funeral Home P.A. of Balto. Co. 22. Randallstown, MD 21133 Liberty Rd. Part 1. Enter the disease or complications that caused the death shock, or heart failure. List only one cause on each line. iter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ years disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Records, P.O. Box 68760

The law requires that the death certificate be executed ig hysician and as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical ttending for use as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day the 9 Unknown detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy perform Yes 2 Physician: completely filled in by the fun-ral director, Be 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Evelyn Division 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Af 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) D0026327 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ross University of Md Medical System Baltimore, MD 21201 Douglas D. 31. Date filed (Month, Day, Year) State MAY 30 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#8perFH, G931, 9/14/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Salik Month 5 MANIAR Year 2012 1400 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death University of Marshmed Medical Cantak BAILIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Months Hours Director N/A 1 🕅 M 2 🗆 F 62 Yrs 04 17 53 India Usual Residence of Decedent 1950 or 28a-f show 10b. County 10a. State 10c. City, Town or Location notified at Director 10d. Inside City Limits MD NA Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral 21 Ralden Ct. 21207 U.S.A. death 11 Marital Status 12. Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 72 hours after þ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify. 3 Divorced 4 Divorced Specify. Completed Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th 12th grade 4yrs Unemployed Unemployed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gulam Hussain Sherbanoo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Faroog A. Marfani-Friend 6629 Hunterswood Circle, Catonsville, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗆 Donation 5 🗀 Other (Specify) cemetery, crematory or other place, Memorial Park 5/26/2012 Woodlawn, Md 21. Signature of Funeral Service Licen March F/H West 4300 Wabash Av Wabash Ave, Baltimore, md 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or their failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ ARTERY disease or condition LORONALT ALSS HSS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed use as the burial-transi Cause (Disease or injury and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No jo Month Dav Pregnant at time of death Year detached the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed ineral Director: After this certificate in ineral Director: After this certificate in inector; pag 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 12 Hospital 2 🗹 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending iniury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital within 24 hours: Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely (Check 3 Zertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 5/25/2012 Klawittzk. CRNT R155115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Klawi HEK marylund BAlhmora 21201 CKNI GREENS ST 22 Sath

Registrar

DHMH 17 Rev 06-2011

State

Date filed (Month, Day, Year)

MAY 3 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death Decedent's Name (First, Middle, Last) Month 05 2012 Physician/ alhoun Murray 3:15 A M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 1432 Perrell Lane Bowie 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday If Under 1 Year I If Under 24 Hrs. **Funeral** Days X_{M2DF} M08/08/1952 Pennsylvania 165-44-4473 59 **Director** 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10b. Count ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State with the Maryland Director PRINCE GEORGE'S X Yes 2 No Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20716 USA 1432 Perrell Lane permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes X No
If Yes, Give Black, White, etc. Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify. "natural", 3 🗆 Widowed 4 🗆 Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Healthcare 12 2 Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ၉ Margaret Calhoun John William Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1432 Perrell Lane, Bowie, MD 20716 Jean Edwards Langley / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial X ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 5/29/2012 Beltsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Si wre of Funeral Service Licenses Maryland Cremation Services, PO Box 1413, Baltimore, MD 21203 Manita 23a. Park 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Ons, t and Death Immediate Cause (Final Physician/ nknown disease or condition resulting in death) Medical Examiner Due to (or as a consequence Sequentially list conditions. Examine r any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month for Day Year Pregnant at time of death 1 Yes 2 Unknown been signed by the s should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 🗌 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No 6 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred Certificate: After 1 1 Natural iniury 5 Pending hours after death. Accident Investigation filled in by the Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3

State Registrar 29b. Signature and title of certifi

31. Date filed (Month, Day, Year)
MAY 3 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 06-2011

29c. License number 02500 29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Denise R. Miller 2012 9:38 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice Of Queen Anne's Centreville Queen Anne's 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 □ M 2 X F Davs Hours (M984/89/1959 220-68-9912 53 Pennsylvania Director Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD 1 Yes 2 No Oueen Anne's Stevensville 20 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 231 Nichols Manor Drive 21666 **USA** items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2X No 9 þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify Year or Dates White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry Je filed win. *al Hygiene. *ar than "r (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Barber Cosmetology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be file and Mental I is marked o ပ John Miller Linda Garverick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sof Health Robert Babcock / Husband 231 Nichols Manor Drive, Stevensville, MD 21666 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State 2 permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 5/22/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph sician/ LIVER FALLINE Medical Due to (or as a consequence of) **Examiner** Circhogia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or liniury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate ass use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy for Pregnant at time of death Month Day 1 Yes 2 g Unknown the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES Completed 1 ☐ Yes 2 ☐ No 3 🙀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) ☐ Oc. P. this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Center 1 Natural 5 Pending after death.

Director: Aff
d in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

State Registrar only one)

29b. Signature and title

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Nume and address of person who completed cause of death (Item 23a) (Type, Print)

2540

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Monum Thierry Musel 2012 2:50 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8712 Fenton Street #102 Silver Spring Montgomery **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months **Director** 230-21-4563 1 X M 2 🗆 F Usual Residence of Decedent 56 1956 May 7, France 28a-f show 10a. State 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified 1 Yes 2 No Silver Spring Montgomery 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be Funeral with 23a 8712 Fenton Street #102 20910 France items Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Hygiene. other than "natural", or iter ent, the Medical Examiner 14. Race - American Indian Armed Force 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Director Non profit Organization ed other t Be 17. Father's Name (First, Middle, Last) it of Health and Mental Health and Mental Health 27 is marked ot or other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) မ Therese Dupuy Guy Musel Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Musel / Brother 5304 Pooks Hill Road Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State = 5 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once, 4 Donation 5 Other (Specify) Final Journey Crematory 5/30/2012 Woodbine, Maryland Si Jure of Funeral Servi Licensee Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Enter be disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ 6 months disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) physician and s the burial-transit Disease or mjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy perform page certificate 1 ☐ Yes 2 🕱 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 **X** No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner at estated. (Check only on nd the of certifie 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) D45880 May 29, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

MAY 3 O

Leon C. Hwang 1396 Piccard Dr. Rockville, MD 20850

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:30 P M 2012 May Walter Lehman Martin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 20508 Millers Church Road Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Hours Country) **Director** 214-36-1330 1932 July 19, Maryland 79 Usual Residence of Deced 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location the Medical Examiner must be notified at Director 1 Yes 2 X No Hagerstown Washington MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 21742 United States 20508 Millers Church Road death 1 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. ō þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 8 Lawn Mowing Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Susan Hege Lehman Ebv Martin Isaac 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Hagerstown, MD 21742 20508 Millers Church Rd. Verna P. Martin / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State any injury or Final Journey Crematory 5/29/2012 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phyliin disease or condition resulting in death) ardiomeg Medical Due to (or as a consequence or Examiner MAD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that the death certificate be executed and I-tran that initiated events Due to (or as a consequence of) resulting in death) Last -burialphysician s the burial Physician/Medical P.O. Box 68760 as. attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, papoua cate has been sig ; page 2 should b 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law autopsy perform performed? 1 Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No ပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director, After this funeral 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 XNatural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within To the

State

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11110 Medical Campus Rd. Hagerstown, MD 21742

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32. Registr r's Sign

ranon

Registrar

29c. License number

K064129

29d. Date signed (Month, Day, Year)

5129/2012

				State of Ma							-		_	e.	
		•	For State Registrar		J. J. J. J. J. J. J. J. J. J. J. J. J. J		tificat			una.		Reg. No	201	2	16859
	Physicia Medic	al .	1. Decedent's Name (First, Middle, Last) Stephen Joseph				_				2. Date of Dea Month May	28°		2	3. Time of Death 18:30 M
	Examir	er	4a. Facility Name (if not institution, give st Carroll Hospital				4b. City,		Location o		r	4c	Ca: County of D	eath rro1	.1
	Funeral Director		Social Security Number 6. Sex			st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Feb. 9,	y, Year)		Country	ice (State or Foreign 1)
	Maryland 28a-f show ptified at	Director	10a. State 10b. County 10b Carrol	1	10c. City,	, Town or Loc	Syke	svi1	le					100	d. Inside City Limits 1 ☐ Yes 2 🔀 No
	with the 23a or st be n	ralD	10e. Street and Number 4410 Raymond Ave	onuo		· · · · · · · · · · · · · · · · · · ·	10f. Zip		21784	<u>'</u>		10g. Ci	tizen of What	Country	
980	e filed within 72 hours after death with the Maryland tial Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	ed by Funeral		2. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		li li	Yes, spec	lent of His	spanic Ori	gin? (Spe n, Puerto	cify Yes or No- Rican, etc.)		14. Race - A Black, W Specify:	merican	n Indian, c.
15-0	72 hour	Completed	15. Decedent's Edu (Specify only highest grade			16a. Deced		k done d	ation Juring mos	t of worki	ng	16b. K	(ind of Busine	ess/Indu	stry
212	iled within I Hygiene, other thai		Elementary/Secondary (0-12)	College (1-4 or 5	+)	_	ngine					E	nginee	ring	3
Baltimore, Maryland 21215-0036	12 should be filed lith and Mental Hy 27 is marked oth r traumatic event	To Be	17. Father's Name (First, Middle, Last) Stephen Hall I	Mobley							e (First, Middle, iret Wi]		Surname)		
Mar	permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		19a. Informant's Name/Relationship (Type Mrs. Anita L. Moble		e)		-		nd Numbe Avent		Route Numbe Sykesvil				de)
ore,	t of Hez If item or othe		20a. Method of Disposition 1) Burial 2 Cremation 3 R		20b. Pl	ace of Dispo	sition (Nan	ne of			Date	20c. L	ocation - City	or Tow	
Itim	nit. Pag artmen ortant: Injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		Lake	e View					'2012		kesvil ĭ HOME	•	MD CHAPEL, PA
8	Depar Impor any ir			reglt M	0076	34					111e, M				JIRI LL, TA
****	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause of each line	cas	[15.	hr the mod	e of dying	s, such as	cardiac o	r respiratory an	rest,		110	Approximate Interval Between Onset and Death
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a conseque	ence of):									
	oe executed ician and burial-transit	al Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):								4	
3760	ificate b ig physi as the b	Medic	IF FEMALE:	l									·	_	
. Box 68760	requires that the death certificate been signed by the attending physishould be detached for use as the I	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 Live Birth 4 Pregnant at 9 Unknown	2 🗌 Fetal	Ideath 3 🗌] Ectopic p] Other (sp		y 			;	23d. Date of Month		ay Year
ls, P.O.	ulres that the signed by all the deta	[출	Part II. Other significant conditions con	tributing to death b	ut not resu l LSL	ulting in the u	nderlying (cause giv	en in Part	l.	i i		use contribute		cause of death?
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. Within 24 hours after death rio the Chuneral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Completed									24a. Was autor perfo 1 🔲 Yes		prior	to comp	y findings available oletion of cause of
/ital	sician: certific lirector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:				Otho	ace of Dea		only one)	$\langle \cdot \rangle$			
of <	ding Phy h. After this funeral d	ite: To	27. Manner of De th 1 Natural 5 Pending	28a. Date of injur (Month, Day	ry :	ER/Outpatien 28b. Time of injury	$\overline{}$	8c. Injury work	4 ⊔ N		me 5 Resid 28d. Describe h			pecify)	
ision	Attendi er death. ector: A by the fu	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ry - At hor	me, farm, stre	M eet, factory	1 🗆 '	Yes 2	-	28f. Location (S			Rural R	oute Number,
Š	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Co	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine	building, etc	my knowle	edge, death o	occurred at	t the time	, date and	I place, ar	City or Tow	use(s) a	ınd manner a	s stated	e(s) and manner stated.
	Fo the Hwithin 24 Fo the Foundlet	₩	only one 3 Certifyin Nuce 29b. Signature and title of certifier	Practitioner: To the	best of m	y knuwladiga.	death occ	. License	ie time, da	de and pla	ice, and due to t	ie cauw	te signed (Mo	er as sta	fed.
9		(7)	· ////	// MD)33	184			Ma	929	201	12
_	101		30. Name and address of person who con	mpleted cause of de	eath (Item	23a) (Type, P	rint)	(en	nte	Da	he f.	24.3	Hope	n. 1	no 21136
187	Sta Registr		31. Date filed (Month, Day York) 2	33. Begisty	s Sig	ALL CONTRACTOR OF THE PARTY OF									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary 20° 2012° 2012° 10:59a Bessie Mae Mathis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Caroline Denton Caroline Nursing & Rehab Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) TN Months Jan 5 1918 1 M 2 🗔 94 Director 219-16-4563 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f sl Examiner must be notified Laurel Sussex 1 Yes 2 X No DE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral Page 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a USA 19956 36060 Way Cross Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White Specify: 3 🗆 Widowed 4 🗆 Divorced Year or Dates er than "natura the Medical E Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education Custodian 12 event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Perry Jess Wilder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36060 Way Cross Road Laurel, DE 19956 19a. Informant's Name/Relationship (Type, Print) Mr. David Mathis (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) liberty Baptist Cemetery 5/24/12 Lisbon, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, FA 21. Signature of Funeral Service License PO Box 195 Sykesvilel, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one caus set and Death Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the k IF FEMALE nse yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 2 No for Month Day Year Pregnant at time of death the detached cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform certificate 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Yes. 2 🗌 No ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury (Month, Day, Year) 5 Pending Natural 1 🗌 Yes 2 🗌 No 2 Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide determined 24 hours a Funeral D filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State

Registrar

29b. Signature and title of certifie

AY 3 0

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30. Name ao

DHMH 17 Rev 7/2009

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Joyce E. Monroe 8:40 PM 2012 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A 4b. City, Town, or Location of Death Union Memorial Hospital Baltimore 5. Social Security Number 219–38–7095 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 ☐ M 2 🔀 F Maryland 01/14/1942 70 10a. State 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore 1X Yes 2 ☐ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 U.S.A. 908 N. Fulton Ave., Unit A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: If Yes, Give Specify: Black 3 Widowed 4 A Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Baltimore City (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Rec. & Parks 3 Acting Director years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore Burrell Gladys Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Williams (Partner) 908 N. FUlton Ave., Unit A, Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Arbutus Cemetery 05/30/12 4 Donation 5 Other (Specify) Baltimore, MD 21. Signame of Juneral Service Licen Joseph de Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, N MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death elevetion MYDERG disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to for selectioned of, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 I Hnknown

Physician Medical **Examiner** burial-trar physician death certificate be Division of Vital Records, P.O. Box 68760

Physician/

Medical

Examiner

Funeral

Director

or 28a-f show notified at

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"natural", or items 23a o

r than "

. Page 1 and 2 should be filed within 72 hours after death virent of Health and Mental Hygiene.
tant: If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner mu

permit. Page 1 a Department of H Important: If ite any injury or ot

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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the Maryland

Exami Physician/Medical as the signed by the attending of the detached for use as cate has been sig filled in by the

9 - Olikilowii			
Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.		contribute to the cause of death? No 3 Probably 4 1 Unknown
		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death (Check on	nly one)	
examiner? 1 Yes 2 No	lospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home	5 Residence 6	Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury Work? M 1 Yes 2 No	d. Describe how injury or	
3 Suicide 6 Could not be 4 Homicide determined		Location (Street and N. City or Town, State)	lumber or Rural Route Number,
29a. Certifier 1 Certifying Physi	cian: To the best of my knowledge, death occurred at the time, date and place, and o	due to the cause(s) and i	manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

AT2438946

29d. Date signed (Month, Day, Year)

05/23/2012

29c. License numbe

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 (Item 23a) (Type, Print) 201 East University Parkway, Baltimore, MD 21218 , MD ardice

L. Cook

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific

within 24 hou

To the Fune

completely fi

(Check only one)

31. Date filed (Month, Day, Year)

MAY 3 0 2012

			For State Registrar	State of Ma	aryland / [Depart		f Health		ental Hy		201		
	Physicia Medi		1. Decedent's Name (First, Middle, Las William J. McG	,						2. Date of De			3. Time of Death 7:07р м	
	Examir		4a. Facility Name (if not institution, give Joseph Ritchie	street and number)		4t	b. City, Town Balt	, or Location	of Death		4c	County of Dea	ath	
	Funeral Director		5. Social Security Number 21 6. Security Number 21 1 Usual Residence of Decedent	7. Age	(In yrs. last birth		f Under 1 Yea lonths Day		Min.	8. Date of Birl (Month, Da 04/20/	y, Year)	C	rthplace (State or Foreign ountry) Cyland	
	laryland 3a-f show ified at	ector	10a. State 10b. County MD N/A		10c. City, Town	or Location		imore	 e				10d. Inside City Limits 1 🏿 Yes 2 □ No	
was y	with the Maryland 23a or 28a-f sho ust be notified at	Funeral Director	10e. Street and Number 1601 Montpelie	r St.		1	10f. Zip Code	21218	 3	10g. Citizen of What C			country?	
0	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	اھا	11. Marital Status 1. X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.		ı		f Hispanic Ori uban, Mexica No Specify:		ecify Yes or No- Rican, etc.) 14. Race - Arr Black, Wh Specify: B.			te, etc.	
970	within 72 hour giene.	Completed	15. Decedent's En (Specify only highest gra Elementary/Secondary (0-12) 10th Grade		+)	16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired) Trash Man						s/Industry		
C buelview.	Id be filed \ Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last) William James	McGowan						(First, Middle, Lberta		Le		
\$ 100 m	nd 2 shoulealth and m 27 is mher traum		19a. Informant's Name/Relationship (7) Gail Colclough		3	171	Raver				tim		MD 21213	
5/17 ₁	t. Page 1 a tment of h trant: If ite ijury or ot		20a. Method of Disposition 1 ☐ Burial 2 【※Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	y)	20b. Place of cerneter On-Si	te C	remat	cory	5-18		Bal	cation - City o	e, MD	
(2) E	permir Depar Impor any ir		21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or comp	N.W.	lliamo							ral Ho imore,	ome PA MD 21217	
MC GOWAN	Physician American and Physician and Physician and Physician and the primal-transit	ical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c.	consequence of		1	r Là					Approximate Interval Between Onset and Death	
7 W Y	requires that the death certificate been signed by the attending phy should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal death		ctopic pregnather (specify)					23d. Date of d Month	elivery Day Year	
1 F	quires that then signed by ould be deta	੬	Part II. Other significant conditions of	ontributing to death be	ut not resulting in	n the unde	erlying cause	given in Part	t I.				or the cause of death? Probably 4 Unknown	
	The law recate has be page 2 sh	Completed								24a. Was auto perfo 1 Yes	psy ormed?	prior to death?	utopsy findings available completion of cause of \$ 2 \Bigcup No	
of Vital	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	cate: To Be	25. Was case referred to redical examiner? 1 Yes 2 No 27. Manne of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injur (Month, Day	ent 2 ER/Ou y 28b. T ; Year) ir	ime of njury	3 DOA C		Jursing Hor			Other (Spery occurred	city//appice	
Division	al or Atten s after deal I Director: ed in by the	Certificate:	3 Suicide 6 Could not of 4 Homicide determined	28e. Place of Inju						28f. Location (S City or Tov			ural Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Direction Completely filled in	Medical	(Check 2 Medical Exami	sician: To the best of e ner: On the basis of ex se Practitioner: To the	camination and/or	r investigat	tion, in my op	inion, death o	occurred at 1	the time, date a	and place	e, and due to the	cause(s) and manner stated.	
	To with		29b. Signature and title of certifier	Pulm			29c. Lice	nse number	12		29d. Da	ate signed (Mon	th, Day, Year)	
7			30. Name and address of person who do	completed dayse of de	eath (Item/23a) (I	Type, Print	3	5/	Do	Huns	NA	2/	2/8	
al.	Sta Registr		MAY 3 0 2012	Seven	A. A.	ale					_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ Ol 2 ear Paul F. Noland 40 A M Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Examiner County of Death Midical 6 PM Social Security Number **Funeral** Sex 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 488-12-6393 91 Country) **Director** 1 🏝 M 2 🗆 F July 24, 1920 Missouri show 10a. State with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f sh notified a Maryland | Anne Arundel 1 Yes 2 X No Severn 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funera 1108 Severn Pines Way 21144 United States items Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, and Mental Hygiene. is marked other than "natural", or iter aumatic event, the Medical Examiner Black, White, etc þ 1 Never Married 2 X Married X Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 44–54 1 Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Communications valend, pau Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Nadia Noland / Wife 1108 Severn Pines Way, Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of May 30, m. 2012 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Donation 5 Other (Specify) Crownsville MD Vet. Cem. Crownsville, Maryland re of Eurieral Ser 22 Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy.,S.E.,Glen Burnie,MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can each line. e on each line Interval Between Onset and Death Immediate Cause (Final Ph_si_i_n disease or condition Medical resulting in death) Due to (Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the at Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 Yes 2 No 3 Probably 4 Unknown been . Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy perform death? 2 X N After this certificate 1 Yes 2 No 1 Yes Division of Vital the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: မ X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) letely filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work 1 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) within To the 29b. Sig ature and title of 2 Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

Name and address of pa

son who completed cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16864 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) 70 PM 20 Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Δ 4 CENTER PALTIMONE Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) (Month, Day, Year) Mir **Funeral** 1 XM 2 🗆 F 218-28-3187 MD Yrs. 10/23/1931 Director 80 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10a. State f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Hampstead Carroll MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21074 2538 Bert Fowler Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc 11. Marital Status Armod Forces?

1 2 Yes 2 No
If Yes, Give 1 🗆 Yes 2 📉 No 1 Never Married 2 Married rr Yes, Give 1952-1960 Year or Dates. þ Specify: White Specify. Baltimore, Maryland 21215-0036 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Electrical Electrician 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Poole Ada Mae ၉ George Nickles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2538 Bert Fowler RD. Hampstead, MD 21074 Joan Nickles-wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ F
4 ☐ Donation 5 ☐ Other (Specify) Cremation 3 Removal from State Winfield, MD South Carroll Crem 5/27/12 = 5 22. Name and Address of Facility Fletcher Funeral Home ature of uperal Service Licensee 21. Sig 21157 254 E. Main St. Westminster, MD any the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Ente Immediate Cause (Final disease or condition PURLIMENIA Physician/ Due to (or as a consequence of) Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant Month Day Year in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No g Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 3 Probably 4 Unknown 1 Yes Division of Vital Records, . Were autopsy findings available prior to completion of cause of death? 24a. Was an ; page 2 perform 1 Yes 2 No Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical examiner? To the Hospital or Attending Physician: Be 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA ည 1 Yes 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Manper of Death Certificate: 1 Yes 2 No Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after deat To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifiei Check only 29d. Date signed (Month, Day, Year) 29 c. License number 29b. Sign ature of death (Item 23a) (Type, Print) who completed cause gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 16865 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 24, Alberta E. Orth May 2:06A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3233 Woodring Avenue Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. '. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Davs Hours 94 213-09-5296 Director Yrs 1917 Maryland August 05. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at Director 10d. Inside City Limits Maryland Baltimore 1 XYes 2 ☐ No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 3233 Woodring Avenue 21234 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. P þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 X Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 2 Homemaker Own Home traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Frank Bomberger Anna Fangmann Department of Health and Important: If item 27 is n. any injury or other traumsones. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3093 Dicks Creek Road Whittier, North Carolina Robert Orth (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Cardens of Faith Cemetery May 29,2012 Rosecble, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evans Funeral Charel & Cremation
8800 Harford Road Parkville, M

23a. Part 1. Etc. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on a failur. List only one cause on each line. 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services Parkville
8800 Harford Road Parkville, Maryland 21234 Interval Between Immediate Cause (Final Onset and Death Physician/ anre ~ O1 disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? should be Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s After this certificate has autopsy perform Yes 2 XXIIIo To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certifical completed filled in by the funeral director; Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 XNo Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 21222 15 out

DHMH 17 Rev 7/2009

State Registrar 31. Date filled (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a&f Per INF 6929 7/09/2012 IH and Mental Hygiene Certificate of Death Registrar Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Daniel C. Poehland Sr May 18, Medical 12:18 PM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) Months Days Hours Director 102-18-5160 1 X M 2 □ F Yrs. 91 Oct 24, 1920 New York and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Baltimore 1 Tes 21 No 10f. Zip Code 21221 10e. Street and Number 8620 Kelso Drive Apt D404 10g. Citizen of What Country? Funeral USA 1. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Never Married 2 Married Black, White, etc. ģ 1 X Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates. 143-46 Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 0 letter carrier postal system Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Max Poehland Edith Rhode 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau Benjamin Poehland/son 179 Sproul Route 352 Malvern, Baltimore, PA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☑ Donation 5 ☐ Other (Specify) Signature of Foneral Service Licensee Ronald S. Wade, 10 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Raltimore, 21201 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) wonted Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Dav Vear Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of Manper of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARIES Charles WD 6701

State

Registrar

31. Date filed (Month, Day, Year)

MAY 3 0 2012

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) Carol H. Allan, MD 31. Date filed (Month, Day, Year) State Registrar

OCME **ORIGINAL**

flelde

Assistant Medical Examiner

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 27 2012 1750 May Albert Dewitt Foster Pollard Sr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Shady Grove Adventist Hospital Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours 218-60-8345 **Director** 1 X M 2 □ F 3-25-1954 Yrs 58 MD Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Randallstown 1 Yes 2 X No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 USA 9337 Edway Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S 11. Marital Status Armed Forces? Black, White, etc. by 1 Never Married 2 XMarried Yes 1 Yes 2 No Specify: If Yes, Give Specify: African-American Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12th Self-Employed Home Improvement Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ruth Austin Leonard Foster Pollard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9337 Edway Circle, Randallstown, MD 21133 Daphine B. Pollard/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6-5-2012 King Memorial Park Woodlawn, MD Signature of Funeral Service Licer 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road. Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ 10 cardial disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-transi attending physician and Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Other (specify) page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 2 No death?
1 Yes 2 No this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? __1 □ Yes _2 □ No 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending injury 24 hours after death. Funeral Director: A Investigation Accident filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2. To the F only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number m.D. 20065505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville MD Winfana 9901 medical 20850 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar VOID CERTIFICATE: #2012 16869 George Pell

SEE CERTIFICATE: #2012 16135

DATE:

June 6, 2012 Diana Barbour

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 19^{Day} Physician/ Jamellia A. Phillips Month 05 2012 12:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Social Security Number 578-58-7319 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 09/22/1945 Birthplace (State or Foreign Country) **Funeral** Days Hours **Director** 1 □ M 2 🛂 F 66 Yrs Washington DC Usual Residence of Deced or than "natural", or items 23e or 28a-f show the Medical Examinar must be notified at 10a. State 10b. County filed within 72 hours efter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD MX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 Funeral 2301 N. Longwood Street USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours eft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other treumetic event, the Medical Examono.e. 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) **4+** Elementary/Secondary (0-12) Secretary Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) いいは Alexander Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2301 N. Longwood Street, Baltimore MD 21216 Daniel Phillips (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, MD St. Stanislaus Cem. 6/1/2012 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Phillip A. Weatherford FS, P.A. 2431 E. Oliver Street, Baltimore MD 21213 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) BREAST CANCER Medical Due to (or as a consequence of): ^{*}Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-trensit Cause (Discase or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No 2 X No Yes 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) 8 examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) HOSPICE 1 ☐ Yes 2 👿 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occ only one med at the time, date and place, and due to 29b. Signature and tiple of ce 29d. Datersigned/(Month, Day, Year) Zi 92 2012 600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKÍE JOŇES 2300 DULANEY VALLEY RD. **CRNP** TIMONIUM, MD 21093

State Registrar

JAMELLIA PHILLIPS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Month Dav Year May UD Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 00 112 If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 234-54-8601 **Director** 1 🔀 M 2 🗆 F 77 Jan. 16, 1935 West Virginia Usual Residence of Decedent 10h County 10c. City, Town or Location Director must be notified 28a-f 1 Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code þ 10g. Citizen of What Country? 23a Completed by Funeral 103 Kuethe Rd. 21060 United States iral", or items 2 Examiner mus 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 1 Yes : Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced 152-158 Year or Dates. White event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Freight Worker Airline other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o ပ Myrtle Ellen Teets Rapheal T. Pyles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Patricia C. Thomas / Daughter 8071 Green Orchard Rd., #13, Glen Burnie, MD 21061 Department of Healt Important: If item 2 any injury or other tonce. other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ₩ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) May 31, Grove Hill Cemetery onation 5 Other (Specify) Shelbyville, Kentucky 22. Name and Address of Facility
Kirkley-Ruddick
421 Crain Hwy., S.E., Glen Burnie, MD 21061 Signat of uneral Se 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year 1 Yes 2 No Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by thrive, cerebrovascular disease Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Atheroscleratic heart distact cate has l performe 2 No Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No filled in by the Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 18W

Registrar

DHMH 17 Rev 06-2011

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Sarka

21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Annapolis

Medical

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 28. Del Carmen Ramirez Ponce 11:40 A M Nestor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MedStar Montgomery Medical Center Olney Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Min Hours Country Director N/A 1 🛣 M 2 🗆 F July 16, 1934 Peru Usual Residence of Decedent show 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sk notified a 1 Tes 2 X No MD Montgomery Germantown 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 20874 Peru 20716 Crystal Hill Circle #G er than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian. Armed Forces?

1 Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Yes 2 If Yes, Give Year or Dates þ 1 Never Married 2 X Married hours after 1 X Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed White Peruvian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) Il Hygiene. College (1-4 or 5+) 12 Retail Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of မ Climaco Ramirez Carmen Rosa Lopez Razuri other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Teodolinda Lino de Ramirez/Wife 20716 Crystal Hill Cir. #G Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ò 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or 5/30/2012 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory Woodbine, Maryland Signature of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart safure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 20 months Physician/ disease or condition resulting in death) Pancreatic Cancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy nerforme Yes 2 X No 1 Yes 2 No Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: မ 1 XInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred the Hospital or Attending 1 XNatural 5 Pending death. 1 Yes after death filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a hours Medical 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) within To the 29b. Signature and title of certifier မ

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 06-2011

chang

18101 Prince Philip Dr. Olney, MD 20852

32. Registra 's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yuanjue Zhang

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11:15 A M Thomas Parker Pollock May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery If Unde Social Security Number Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) 369-52-7780 Director 1 X M 2 □ F 1949 63 Feb 11, Ohio th end Mental Hyglene. 27 is marked other than "natural", or itsms 23a or 28s-f show trsumatic event, the Medical Examinar must be notified at 10a State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Montgomery Germantown 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 19019 Red Robin Terrace 20874 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 5 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 2 should be filed with h end Mental Hyglen 7 is marked other th Security Company Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Pege 1 and 2 should be Department of Heelth and Mem Important: If Item 27 is marke sny injury or other trsumatic e Brayton Pollock Betty Jane Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myriam Khalifa / Ex-wife 220 Stonington Rd. Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 5/28/2012 Woodbine, Maryland 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ease or condition Lung Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulssaan of Line) Due to (or as a consequence of) ed by the attending physicien end detached for uss as ths buriei-trensit The law equires that the death certificate be executed Cause (Disease of Injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Pregnant at time of death signed by this id be detach P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Records, c te has teen sig ; page 2 should b 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy tal or Attending Physician: The lars effer death.
al Director: After this certific, te he led in by the funeral director, page death? 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) HOSPICE 1 ☐ Yes 2 🖾 No |2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours of To the Funeral DI completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Secrifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

Rockville

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Road R

6001 Muncaster Mill

R143201

5.27.2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Physician/ 2012 BERNARD POLAKOFF 10:10P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OWINGS MILLS BALTIMORE 4730 ATRIUM COURT, #625 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthpie Country) MD Age (In vrs. last birthday 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 🗆 F Hours (Month Day Year) 6 95 Yrs Director 213-10-5452 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be Funeral items 23a 4730 ATRIUM COURT, #625 21117 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. "natural", or item edical Examiner n 14. Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) 12 College (1-4 or 5+) should be filed with and Mental Hygien is marked other th OWNER REAL ESTATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LOUIS POLAKOFF ANNE SHILKROD 1 and 2 should bit Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY POLAKOFF/WIFE 4730 ATRIUM COURT. #625, OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or other 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW 05/29/2012 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licenses MD 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a con-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine and Due to (or as a consequence of) physician Physician/Medical The law requires that the death certificate be Box 68760 the attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day 5 Other (specify) Pregnant at time of death the i Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has certificate 1 Yes 2 No To the Hospital or Attending Physician: ¹ within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 🗌 Yes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No filled in by the funeral 1 Natural 28d. Describe how injury occurred Certificate: iniury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of avanigation and/or inventioning in my policy in the property of the property 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature completed cause of death (Item 23a) (Type, Print) 5 Marshalee Dr

DHMH 17 Rev 7/2009

State Registrar Date filed (Month, Day, Year,

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			For State Registrar		-	•	rtificate of				Reg. No	0.0	112	16	587	
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with the Ma a or 28a-f	Funeral Director	10e. Street and Number 6000 Bellona A	ve .			10f. Zip Code 10g. 21212						hat Coun				
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DIVISION OF VITAL To the Hospital or Attending Physician:	ctor: After the funeral	Certification: 1	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Hemicide 5 Pending Investigation 6 Could not bedetermined	0	(Year) Ir	njury	Wor		No 2	28d. Describe	how inju	ry occurre	ed		ımber,	
Spital or	neral Dire		29a. Certifier 1. Certifying Ph	building, etc	of my knowledge						cause(s) and ma				
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	Registr	ar	MAT 3 U 20	14 Cleans	1 B. 19	Pa	Was .									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10th 1:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death MEDICAL CENTE UNIVERSITY OF MARTHAND BALTIMORE CITY 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 unk Social Security Number 6. Sex If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 232-46-0431 **Director** 1 🗆 M 2 🗓 F 82 Oct 4, 1929 Usual Residence of Dec 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified MD Baltimore 1 X Yes 2 No 5 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? must be Completed by Funeral 23a 1217 W. Fayette Street 21201 USA "natural", or items edical Examiner mu unk 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or 1 Never Married 2 Married ☐ Yes 2☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give 3 Widowed 4 Divorced black Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry unk (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University of MD Medical Ctr 22 S. Greene Street Baltimore, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state permit. or Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, theart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events burial-transi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery the Hospital or Attending Physician: The law requires that the death of thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the atter in the past 12 menths?

1 Yes 2 No been signed by the atter should be detached for Month Day 1 Yes 2 9 Unknown P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, HYPER TENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 5. GREEN 31. Date filed (Month, Day, Year) Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kose Month 20 May 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death North WEST Baltimore Randallstown Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral Director** 1 🗆 M 2 💢 214-44-3919 65 Yrs. APR. 3 1947 MARYLAND r 28a-f show notified at 10b. County permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MIDDLE RIVER MARYLAND BALTIMORE CO. 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral U.S.A. 15 OLD KNIFE CT. 21220 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XXNo
If Yes, Give 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: 3 Widowed 4 Divorced Completed Specify: BLACK Year or Dates. Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Co1 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Councelor Elementary/Secondary (0-12) College (1-4 or 5+) SAFEHOUSE 12yrs Director/Substance Abuse 4yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WENDELL DAVIS CAROLINE ELLIOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicole J. Rose/Daughter 21234 2206 Whitcomb Cir. Apt C., Parkville, Md., 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 M Other (Specify) FNTOM BM cemetery, crematory or other place) HOLLY HILLS MEMORIAL CC-62-12 MIDDLE RIVER, MARYLAND 21. Signature LLIAM COMMUNITY FUNERAL HOME P.A. 06 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Ph_sician/ Sipsis disease or condition Medical resulting in death) Due to (f as a consequence of): **Examiner** Peritonitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-transi (an Cer Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown P.O. I been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Physician: The law certificate has autopsy performed 1 Yes 2 No Yes 2 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital Other: ျ 24 hours after death.

Funeral Director. After this of the fulled in by the funeral dil 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 5 Pending (Month, Day, Year) 1 Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D65843 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Court Road, Randallstown, MD 21133 Kafrouni 31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #195 Per FH G927 5/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ 0730AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, 4c. County of Death rederic Nursino 6. Sex (In yrs. last birthday) Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Min. Hours M 2 D F **Director** NV 5, Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 No 10e. Street and Number ò 10g. Citizen of What Country? 23a Funeral a 70 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify "natural" Completed 3 Widowed 4 Divorced and Mental Hygiene.

Is marked other than "natur aumatic event, the Medical" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) 9 + Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 040 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) int of Health a t: If item 27 is or other tra /Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Department o important: If any injury or once, 28 4 Donation 5 Other (Specify) 21229 21. Signature of Figure Service Licensee Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of bying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter oncernying Cause (Disease or injury Due to (or all and the burial-trar that initiated events resulting in death) Last as a consequence of the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown signed by Other significant conditions contributing to death but not resulting in the 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate has 2 No Yes 1 Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check icense numbe 29d. Date signed (Month, Day, Year) use of death (Item State Registrar X DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ May 26, Irene E. Roberts 2012 5:10 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Gilchrist Hospice Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/04/1922 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min Months 215-18-3776 Director 1 🗆 M 2 💢 F 90 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director 1 🗌 Yes 2 😾 No Maryland Baltimore Woodlawn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 6714 Edward Avenue 21244 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3₩Widowed 4 □ Divorced "natural", Completed White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene.
item 27 is marked other than
other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Cosmetologist Hairdressing 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Gray Ida B. Hisley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 6714 Edwards Avenue Woodlawn, Dennis Roberts - Son Maryland 21244 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Department of Important: If it any injury or o 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State Atlantic Crematory 05/29/2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 21. Signature of Funeral Ser omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final Physician/ weeks disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate sause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) signed by the at d be detached for 1 Yes 2 N 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed page 2 1 Yes 2 No 2 No To Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No s after death. Investigation Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar 29b. Signature and title of certifier

NOL

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10.SEPH

30

CEDAR

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

29d Date signed (Month, Day, Year

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Villa Blanche F	KIZZI	1- For State	S	ate of	Maryl	and / I		rtment <i>tificate</i>			and	Ment	al Hy	giene		2	0	2 68
Dhynia	:/	Registrar 1. Decedent's Nam	a/Eiret Midd	le Last)			Ceri	ıncate	OI DE	eaun				2. Date of D	Reg. N	0.		Lo Time of Dark
Physic Medical Exam				lla		Blan	oho	1	Rizz	iori	;			Month	Da		ar	3. Time of Death 1825 hrs
		4a. Facility Name (reet and n		CHE					ocation of	Death	May 26		4c. County	of Death	
		Gilchrist Ho	spice Cer	ter					To	owson	1					Baltimor		
Funeral		5. Social Security I	Number	6. Sex		7. Age (In yrs. Ia	st birthday	If	Under 1	Year	If Under	24Hrs.	8. Date of	Birth(M	M/DD/YYYY		thplace (State or
Director	ı	257-24-9	9678	1 M	2X F		89	9	Yrs. M	onths	Days	Hours	Min.	Nov.	10.	1922	Foreig Co	^{on} untryGeorgia
	1	Usual Residence of	f Decedent			.							L					
W ROY		10a. State	10b. County			10		Town or Lo										10d. Inside City Limi
land f show	5	Maryland	Balt	more	2		Not	tingl										1 Yes 2 X
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72 bours after death with the Maryland n "natural", or items 23a or 28s-f she all Examiner must be notified at once		54 Suri	ey Lar								212					U.S.A.		
tems at be	Funeral	11. Marital Status 1 Never Marri	ed 2 M		2. Was Dec Armed F		er in U.S							cify Yes or ican, etc.)	No-	14. Race White		ican Indian, Black,
er der		3 X Widowed		1	Yes Yes, Give Yes	2 er 1 Q /, 3	No 2_10	/.5 I 1	Yes	2 🔽	No.	cooifir				Specify:	Whi	ito
urs afi tural'	J b	15. Decedent's Ed						16a. Dece					nd of wo	rk done	16b	. Kind of Bu		
72 hou	1 5	Elementary/Seco		Ť	College (during	most of	working	g life. D	O NOT u	se retire	d)	Ur	nited	Stat	tes
5-0036 led within 72 hou Hygiene. other than "mat the Medical Exa	Completed	12							Wind	low (Cler	ck			PC	stal	Serv	vice
5-0 led w Hygie othe		17. Father's Name	(First, Middle	Last)							18.	.Mother's				n Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	8			nam		West	perr				\perp			Willa		Coll		
Should and Martic on martic on	유	19a. Informant's Na				1.										City or Town		
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Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr		1 X Burial 2		з 🗌	Removal fr	rom State	СГ	ematory or	other pla	ace)							-	•
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/Medical		failure. List on	ly one cause	on each l	ine.									,		•		Between Onset and Death
Examiner		Immediate Cause (or condition resulting			to (or as a		ence of):			_	_						_	
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that the ned by ti		Part II. Other signif	ficant conditi	ons cor	ntributing to	death bu	it not res	ulting in th	e underly	ying cau	ıse give	n in Part	l.	23e. Dio	tobacc	use contrib	oute to t	the cause of death?
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of Vital Records, of Physiciae: The law require the christicate has been sineral director, page 2 should be	9	examiner?	2 No	Hosp	ital: 1 🗸 1	npatient	2 🗌 E	R/Outpatie	nt 3	DOA	Oth	ner ₄ 1	lursing I	lome 5	Resid	lence 6	Other:	
iog Ph After t funeral	E	27. Manner of Death	1		28a. Date (Month	of Injury , Day,Year)	2	28b. Time o	f Injury	28c.	Injury a	at Work?			e how ir	jury occurre	ď	
tteodi leath. tor: / the f	aţi	1 Natural 2 Accident	5 Pend	ing tigation	fd 5	-12-	12	unkno	wn	1[Yes	2 X N	。 f	a11				
Divising pital or At ours after deral Directification by	Certification:	3 Suicide	6 Coule	not be			- At hom	ne, farm, st	reet, fact	tory, offi	ice build	ding, etc.	28	or Town.	(Street State)	and Numbe	r or Run	al Route Number, City
	3	4 Homicide 29a. Certifier		mined	(Specify)								14	опе 8(iote	MIDAT	TIE	DIVU.
To the Hos within 24 h To the Fur completely	Sa	(Check only	Certifying Ph Medical Exa															
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DHMH 17 Rev 1/2001

Registrar

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5 Snyder 2026 Jacob Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UMMC Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) 217-40-7629 Director 1 **X** M 2 □ F 68 July 15, 1943 Maryland 28a-f show 10a. State aţ 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 ☐ Yes 2 🙀 No MD Baltimore SparrowsPoint 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral within 72 hours after death with 6709 River Driver Road "natural", or items 23 dical Examiner must 21219 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' 1 X Yes 2 I If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: white 3 Widowed 4 X Divorced '61-65 Completed Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business/Industry unk (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygien 7 is marked other th 12 laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jacob William Snyder permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Rita Mary Stefan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara Urtis/sister 3206 River Driver Road Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) 22 Name and Address of Facility
State Anatomy Board
Baltimore, MD 2120 655 W. Baltimore Street Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ hemorrhas ntracerebra disease or condition resulting in deat Medical Due to (or as a consequence of) **Examiner** STYOKE Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Dur to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Yes 2 No signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Alcoholism 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Dementia Korsakoff's 24b. Were autopsy findings available 24a. Was an cate has autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 🖄 Natural 5 Pending ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 101386 Stephanie Lueckel on who completed cause of death (Item 23a) (Type, Print) S+. Baltimore

DHMH 17 Rev 06-2011

State Registrar Greene

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 2012 \$00P M Harold Augustus Spriggs Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince Georges Doctor's Community Hospital Lanham 9. Birthplace (State or Foreign 8. Date of Birth
(Month, Day, Year)
July 1, 1950 If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Hours **Director** 579-64-0274 1 □XM 2 □ F 61 Washington DC Usual Residence of Decedent 28a-f show ntal Hygiene. ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Prince Georges Landover 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3502 Hubbard Rd; Apt 104 20785 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 11College (1-4 or 5+) landscaper private industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harold Augustus Spriggs Sr. Rosa Lee Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Dewayne Spriggs - son 15311 Dove Heart Ln; Bowie, MD 20721 Department of Health Important: If item 27 any injury or other to 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) 21, Sign thre of Euneral Service Sicensage D1 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cute by po xin.
Due to (or as a consequence of): Physician/ Medical Examiner Shock Sequentially list conditions, ir any, reading to immediate cause. Enter Underlying Examine Cause (Disease or injury and that initiated events resulting in death) Last use as the burial-trai Due to (or as a consequence of attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Vear Pregnant at time of death 4 Pregnant been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 perform Coagulopa 1 Yes 2 No 25. Was case re crred to medi examiner? 1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 12012 Abebe Amare MDD52 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belle Point Drive Greenbelt,MD 20770 Abebe 7705 Amare W. 31. Date filed (Month, Day, Year) State MAY 3 0 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 4:31 AM Shewell Ethel may 21 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bultimore Harbor If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth Funeral Months Days 02/08/1940 1 □ M 2**K** F 217-38-7533 72 Marvland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at Director MD 1X Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 Washington Boulevard 21230 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White Completed by 3 ☐ Widowed 4 🏿 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Barmaid Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Lawrence E. Bennett Mary Agnes Holtman ပ Health and Nem 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Agnes Smith (Sister) 591 Terrace Avenue, Baltimore MD 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If its any Injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Ardent Cremation 5/29/2012 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Phillip A. Weatherford FS, P.A. De 2431 E. Oliver Street, Baltimore, MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis /Medical Due to (or a a consequence of): Examiner PNeumonia Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examine Uninary Tract infection
Due to (or as a consequence of): P.O. Box 68760, or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Respiratory Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐Yes 2 ☐No 1 □Yes 2 □No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Zaidi, MD May 22 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Taki Zaidi, MD

31. Date filed (Month, Day, Year)

3001 south Hanova STreet Baltimane, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	For State Registrar	State of M	faryland / [•	artment of F		and M	Re	eg. No. 2	012	1688	
Physicia /Medic Examin	n al	Ned Sydnor Facility Name (First, Middle Ned Sydnor) As Facility Name (If not institution)		·)		4b. City, Town, o	r Location	of Death	2. Date of Deat Month May 14	Day	Year	3. Time of Death 2:50 AM	
Funeral Director	-	Golden Living 5. Social Security Number 224-48-5193		ge (In yrs. last bir 73	thday) Yrs.	Hagers If Under 1 Year Months Days	town If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Jan 29,	Year)		on ice (State or Foreign y) ginia	
B Maryland a-f ahow	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca MD Washington Hagers								10d. Inside City Limits 1 □ Yes 2 □ No			
eath with the 23a or 26	Funeral Director	10e. Street and Number 750 Dual Hgwy	12. Was Deceden	t Ever in U.S.	12.1		21740	igin? (Spe	0g. Citizen of What Country? USA 14. Race - American Indian,				
7.72 hours after death with the Maryland 7.72 hours after death with the Maryland "nature!", or itema 23a or 28a-f ahow edicel Examiner must be notified at	þ	1 Never Married 2 Mar 3 Widowed 4 Divorced	?]No :		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2)(1) No	Specify:		Rican, etc.)		ck, White, et	te.		
d within 72 h jiene. ir then "netu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 15. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired) truck driver							16b. Kind of Business/Industry transportation				
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Definit. Pages 1 al Department of Heal Mocriant: If Item Iny injury or othe		1 Burial 2 Cremation 4 Donation 5 Other (S 21. Signature Funeral Service RO 1.2 1	Specify) in state	θ	22	Name and Addre	ss of Facili			. Balti	more S	Street	
Physician /Medical Examiner	Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):												
te be executed ysicien and ne burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	val	Verse	l De	10.70	10 years						
that the death certificat sed by the attending phy deteched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)								23d. Date of delivery Month Day Year			
es il	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Fa						l.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
The law ete hes b page 2 s	Completed								autops perfora	24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
ng Phys Iter this neral di	Certification; To Be	25. Was case referred to ca examiner? 1							(Check only one) me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
A 2 6 6	al Certifi	3 Suicide 6 Could determ 4 Homicide 29a. Certifier 1 Cartifyii	ng Physician: To the bes	njury - At home, fa etc. (Specify) st of my knowledg	e, deat	h occurred at the tri	me, date a	nd place,	28f. Location (Si City or Town	n, State) ause(s) and m	anner as sta	ated.	
To the Hospital or within 24 hours after to the Funeral Direction completely filled in	Medical	29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Madical Examinar: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										the cause(s)	
Sta Registr	_	30. Name and address of person 31. Date filed (Month, Day, Year,	13 VU/ 32 Presis	368 M	il	St A	osev	102	on, C	102	174	0	

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ard Somme	erfel	State of Maryland / Department of Health and Menta 1- For State Registrar Certificate of Death	1 Hygiene 2012 1688
Physici lical Exami		1. Decedent's Name (First, Middle,Last) Edward Sommerfeldt	2. Date of Death Month Day Year May 14, 2012 A Stime of Death 2214 hrs
		4a. Facility Name (if not institution, give street and number) Gilchrist Hospice 4b. City, Town, or Location of D Parkville	
Funeral Director		5. Social Security Number 463-52-6648 1 N M 2 F 74 Vrs. If Under 1 Year If Under 2 Hours 463-52-6648 1 N M 2 F 74 Vrs. Months Days Hours Usual Residence of Decedent	4Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)Texas
D Z1Z13-0U36 Moute be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show any natic event, the Medical Examiner must be notified at once.	al Director	10a. State 10b. County 10c. City, Town or Location MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 8800 Walther Blvd #1118 21234	10d Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? USA
after II.	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind)	white, etc. Specify: white
permit. Pages 1 and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturi injury or other traumatic event, the Medical Exami	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use 12 8 professor	
ould be file I Mental H marked o	Be	Edward Ernest Sommerfeldt Mary	Lovelace or Rural Route Number, City or Town, State, Zip Code)
permit. Pages I and 2 sh Department of Health and Important: If item 27 in injury or other traumat		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	#1118; Parkville, MD 21234 Date 20c. Location - City or Town, State
permit. Pa Departmen Important injury or o		655 W. Baltimo:	State Anatomy Board re St; Baltimore, MD 21201
	l Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardinal disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
	Physician/Medical	AMENDED 23a,27,per me,g928 6-1-12 sm IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions AMENDED 23a, 27, per me,g928 6-1-12 sm 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre 5 Other (Specify) 9 Unknown	egnancy 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death?
The law requires that icate has been signed by page 2 should be deta	Completed by	Contributing to death but not resulting in the underlying cause given in Part I.	1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No
Attending Physician: The death. ctor: After this certificate by the funeral director, page	To Be	25. Was case referred to medical examiner? 1 Ves 2 No 27. Manner of Death 1 Natural 5 Pending (Month, Dey, Yeer) 28a. Date of Injury (Month, Dey, Yeer) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	rsing Home 5 Residence 6 Other: 28d. Describe how injury occurred
To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the f	al Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	28f. Location (Street and Number or Rural Route Number, City or Town, State) and due to the cause(s) and manner as stated
To the within To the comple	Medical	pone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E.	ad at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) May 15, 2012
Sta	ate rar	Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltin Date filed (Month, Day, Year) 32. Refistrar's Signature	timore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:25 PM Robert Simmons 0.5 - 2012 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Lonic Hospice 8. Date of Birth If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Days Hours Months Min. Sept 15, 1949 222-33-4378 62 Director 1**X**] M 2 □ F Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 🗌 Yes 2 ⋤ No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò should be filed within 72 hours after death with t and Mental Hygiene. is marked other than "natural", or items 23a Funeral 105 Times Square 21801 USA 11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces? unk 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc 1 Never Married 2 Married \$ timore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation un (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) unk Elementary/Secondary (0-12) unk permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) ည unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paulette Warner - niece 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in State cemetery, crematory or other place 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral Service Lice Ronald Made, Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year signed by the at d be detached for 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown cate has been sig ; page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 2 1 No certificate Yes 2 1 Yes director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 2 00 မြ 1 Inpatient 2 ER/Outpatient 3 IDOA After this funeral 27. Manner f Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Watural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death, To the Funeral Director: A completely filled in by the fo Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29c. License number cause of death (Item 23a) (Type, Print)

State Registrar EASTERN SKARE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Alan Michael Stambaugh Medical 9:45P May 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) February 26,1950 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Months Director 262-96-1761 1 1 2 M 2 □ F 62 Baltimore, Maryland 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d Inside City Limits Director Maryland Baltimore White Hall 1 Yes 2XXNo 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2617 Garrett Road 21161 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ò Completed by 1 Never Married 2 Married 1 Yes 2XXNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4 or 5+) Director of Technology Harford Christian School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wilbur Allen Stambaugh Dorothy Ruth Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 sh Department of Health ar Importent: If item 27 is eny injury or other treu Ada Stambaugh (Spouse) 2617 Garrett Road, White Hall, Maryland 21161 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Evans Funeral Chapel-Bel May 30, 2012 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Evans Funeral Chapel & Cremation Services-Monkton
16924 York Road Monkton, Maryland 21111 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or helat failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ letasta disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical es the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ó in the past 12 months? Pregnant at time of death Month Day Year certificate has been signed by the e irector, page 2 should be detached f Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed' death? 2 🗌 No Yes 2 No 1 Tes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 1 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge death occurred at the time date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUMAR 31.: Date filed (Month, Day, Year) NAY 3 0 2012 State Registrar

Box 68760

P.O.

Records,

Division of Vital

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State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1548 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Mandrin Inpatient Care Center Harwood Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. (Month, Day, Year, 513-26-4779 **Director** 1 🛚 M 2 □ F June 14, 1928 Usual Residence of Decedent 83 Kansas 28a-f show 10c. City, Town or Location the Medical Examiner must be notified at **Funeral Director** 10d. Inside City Limits 1 X Yes 2 No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 12219 Fleming Lane 20715 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 2 . Baltimore, Maryland 21215-0036 1 LA Yes 2 L No. If Yes, Give 1949 – Year or Dates. 1975 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) **OSI** and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Special NCIS Investigator Air Force Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Schmidt Minnie Van Dorm Dorn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenna Schmidt/ Wife 12219 Fleming Lane Bowie, MD 20715 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 6/5/2012 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each liny Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No 1 Tes 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: ည 1 Yes \square Nursing Home 5 \square Residence 6 \square Other (Specify) C1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred * Natural 5 Pending after death Director: A d in by the f Accident Investigation 1 🗌 Yes 2 🔲 No 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a **To the Funeral D**completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Name and address of pe o complete cause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Year Juanita D. Sentz 2.45 AM 05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE, MD If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Director 215-46-5509 1 M 2 65 July 07,1946 Baltimore, Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Maryland 28a-f Hamilton 1 X Yes 2 □ No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6040 Harford Road 21206 United States ral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural" 3 Widowed 4 XDivorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) 10 Never Worked Disabled other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental ⊦ marked o Herbert W. Blevins Dolores E. Schaffer and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a: If item 27 is Gail Voelker (Daughter) 3720 Wolf Trail Drive, Abingdon, Maryland 21009 20b. Place of Disnosition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 Burial 2 XCremation 3 Removal from State Evans Funeral Chapel-Bel May 31, 2012 4 Donation 5 Other (Specify) Forest Hill, Maryland Air Signature of Euneral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville
8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, pr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat dallure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Hupoxic Hypoxic Respiratory

Due to (or as a consequence f): disease or condition resulting in death) Failure mounte Medical Examiner nours Dirahon Memonie Sequentially list conditions. If any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) Encephalopathu that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebrovascular Accident, Deep Venous Thrombosis, 1 Yes 2 No 3 Probably 4 Unknown Completed Diabetes Mellitus, CAD, Dementia, SEPCIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 \ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred To the Hospital or Attending 5 Pending 1 Natural injury within 24 hours after death.

To the Funeral Director: A completely filled in by the f Accident Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, Titains RES OOC 391 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011 NUTAN

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och Raven Blud Balt, mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Miriam Ann Sobus May 2012 Medical P 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center Parkville Jnder 1 Year | If Under 24 Hrs. **Baltimore** Social Security Number 9. Birthplace (State or Foreign Country) Baltimore, Maryland 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Months Days Hours Director 81 214-26-0580 January 19. 1931 Usual Residence of Decedent 28a-f show 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location Director Baltimore Parkville Maryland 1 Yes 2 X No 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 8800 Walther Blvd. 21234 United States items ? 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent 2.5. Armed Forces? 1 ☐ Yes 2 🕅 No Black, White, etc. ō þ 1 Never Married 2 Married hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Wildowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and 2 should be filed within Health and Mental Hygiene. tem 27 is marked other tha Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Kaisler Mary E. Smlsal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 521 Little Current Drive, Annapolis, Maryland 21409 Kathleen Stover (Daughter) injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State . Page 1 1 Dremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Sacred Heart of Mary June 02, 2012 Dundalk, Maryland 21. Signature of Fuperal Service License 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Lisease or imjury that initiated events and -trar resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown No ģ Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ulmonary 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 1 Yes 2 No Yes Division of Vital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed within 2. To the F 3 X certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 2012 LRAP MIN completed cause of death (Item 23a) (Type, Print) Walthor Blod Pockville MD 21234 8800 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jane A. Stine 2012 1:48 DM Mav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10221 Westwood Drive Columbia Howard 8. Date of Birth (Month, Day, Year) Feb. 5,1925 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min Days Hours 213-20-7538 Director 1 □ M 2 💢 F 87 Maryland show iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗓 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 10221 Westwood Drive death 1 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White "natural", 3 X Widowed 4 Divorced Year or Dates of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Administration M&T Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herman Schafer Caroline Filip t. Page 1 and 2 should by rtment of Health and Mer rtant: If item 27 is mark. 19a. Informant's Name/Relationship (Type, Print)

Janet Stine-Bolduc/daughter Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 10221 westwood Drive Columbia, Maryland 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, Date 1 X Burial 2 Cremation 3 Removal from State 6/2014OwingsMills, Maryland Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 6 21. Signature of Funeral Service License Stephanie Custer 22. Name and Address of Facility MacNabb Funeral Home P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician a. Metustati disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examir Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the as JE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Por signed by the at d be detached for Pregnant at time of death 1 Yes 2 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 🗌 Yes 2 😾 No 2 💢 No Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 🔀 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 X Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pending injury 2 Accident
3 Suic Certifica Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 1)4437 LNO

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul William
12-03950 Sleman
Unk Unk
1- For State
Registrar
Physician/
Medical Examiner
Paul

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

IIK OIIK		1- For State Certificate of Death Registrar		g. No. 201	2 1689
Physicia	ın/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month	Day Year	3. Time of Death
ledical Examii		Paul William Sleman 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deatl	May 24, 20	12 4c, County of Death	1804 hrs
		4a. Facility Name (if not institution, give street and number) 1515 November Circle #304 Silver Spring		Montgomery	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	_	h(MM/DD/YYYY) 9, Birt Foreig	
Director		215-46-3683 1 M 2 F 64 Yrs. Months Days Hours Mir	07/05/	1947 Co.	antry) DC
any	-	Usual Residence of Decedent 10a. State			10d. Inside City Limits
È.,	5	Maryland Montgomery Silver Spring			1 Yes 2 No
Maryla	6	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she trammatic eveot, the Medical Examiner must be outfifed at once.		1515 November Circle, Apt. 304 20904 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	necify Yes or No-	United 14. Race - Ameri	
leath w	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto		White, etc.	
after d	by Fi	3 Widowed 4 X Divorced If Yes, Giva Year 1 67-70 1 Yes 2 X No specify:		Specify:	White
hours fratur		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ref		16b. Kind of Business/II US Botanic	•
36 thin 72 te.	Completed	3 Greenhouse Grower		Gardens	-
5-00 led win Hygien other		17. Father's Name (First, Middle, Last) 18.Mother's Name	e (First, Middle, M	laiden Surname)	·
nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", other traumatic eveot, the Medical Examiner	Be	John B. Sleman Mildred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	0'Lear	y her City or Town State	Zin Code)
MD 2 id 2 shoul ulth and M m 27 is m aumatic	٩	Meagan P. Sleman/Daughter 18868 Bent Willow Cir			
e, N 1 and 1 Health item	Ì	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	Town, State
MOF Pages tent of tut: If		4 Donation 5 Other Specify: Metro Crematory Inc. 05/	30/2012	Baltimore,	Maryland
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If iten 27 is m injury or other traumatic.	İ	21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of FacilityCre	mation S	Society of N	Maryland Inc
	4	23a. Part Penter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac	<u>1. Balti</u> or respiratory arre	more, Maryl	and 21228 Approximate Interval
Physician /Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease	, ,		Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):			
,	7	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated			
Hansit and Market		events resulting in death) Last Due to (or as a consequence or): d.			
760, cate be executed physician and he burial - transit	Medical	UNPENDED AMENDED	-		
760 ficate b g physi		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancv	23d. Date of delivery	ay Year
Box 687 The death certific The attending in the attending in the as th	iciar	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	unoy	Wester	1001
D.O. BOY that the deatl ned by the atl detached for	Physician/	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did to	bacco use contribute to	the cause of death?
Division of Vital Records, P.O. Box 68760, ral or Atteoding Physiciao: The law requires that the death certificate be as after death. **I Director: After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the burit	Ď	Chronic Alcohol Abuse		2 ✓ No 3 Prob	
cords, P.O. law requires that has been signed b	Completed		24a. Was a		topsy findings available ompletion of cause of
ecol he law te has age 2 sl	dmc		perform	med? death?	
tal Recting: The certificate ector, page	BeC	25. Was case referred to medical 26.Place of Death (Check	only one)		
of Viting Physici	10 1	1 V Yes2 No	-	Residence 6 🗸 Other	Scene
ion of Vital Rec teoding Physiciae: The eath. for: After this certificate i the funeral director, page	5	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 V Natural 5 Pending	∠8a. Describe n	ow injury occurred	
r Atter er deat irector	ficat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.		treet and Number or Ru	ral Route Number, City
Div pital or ours aft filled in	Certification:	Suicide 6 Could not be determined (Specify)	or Town, St	ate)	
Division To the Hospital or Atteodi within 24 hours after death. To the Fuoeral Director: \(\) completely filled in by the fi	- 1	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred			
To th To th comp	Medical	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and hanner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor	
1341	_	O.C.M.E.		May 25, 2012	
OCME		30. Name and address of person who completed cause of death (Item 23a)			
		Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Balti	more, MD 21	223	
St	ate	31. Date filed (Month, Day Yoor) 32. Registrar's Gignatura			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ - in July - b-2 8 201 tone Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7: nora NPSZTA Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Hours (Month, Day, Yea 2/6/1969 153-66-0700 **Director** 1 XM 2 □ F 43 or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f sho Director MDBaltimore Randallstown 1 Tes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4402 Windy Hill Road 211.33 USA · death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give Specify: African-American Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) BŒ 12th Maintenance Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental h Important: If item 27 is marked any injury or all Jesse E. Stone Ardelia Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4402 Windy Hill Rd., Randallstown, MD 21133 Karen D. Stone/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5-25-2012 Baltimore, MD Metro Crematory 21. Signature of Funeral Servic see 22. Name and Address of Facility Wile Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 fiplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. 23a. Part 1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ prement disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed fin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth 2 Fetal death
4 Pregnant at time of death 3 Cectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year 2 No detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 XNo 1. Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person no completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death Physician/ Month 25/AM 5-Willa Royce Shinholt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 8. Date of Birth (Month, Day, Year) 10/18/1937 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Country) Maryland Months Hours 1 □ M 2 1 F Director 219-34-5982 74 27 is marked other than "natural", or items 23e or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Baltimore Sykesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1442 Buckhorn Road 21784 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. δ 1 Never Mamed 2 Mamed Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Banking Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Department of Health and Mant, Important: If item 27 is marked any Injury or other transmissions. Harold Raymond Smith Wilma Gatrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6220 Longleaf Pine Road, Eldersburg, MD 21784 Jeffery A. Shinholt / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/29/2012 Chesapeake Crematory Beltsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Manuta roma Maryland Cremation Services, PO Box 1413, Baltimore, MD 21203 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ACUTE RESPIRATORY Physician/ disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending Analysis completely filled in by the funeral director. Exam Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed ARTERIAL DISEASE PERIPHERAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy MELLITUS DIABETES 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 2 No Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No 2 ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOOMD 200 MEMORIAL AVENUE, WESTMINSTER, MD 2/15 MD KHOO 32. Registra's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ harles Schuchar Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Loch Kaven Community Living Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral X**□ M 2 □ F Months Days Hours (Month Day Year) 91 Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City. Town or Location 10d. Inside City Limits **Funeral Director** X□ Yes 2 □ No MD **Baltimore City** Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 906 East 30th Street 21218 **USA** 12. Was Decedent Ever in U.S. Armed Forces?

★□ Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify. 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **UNK** UNK UNK 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည UNK UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. White / Friend 912 East 30th Street, Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/29/2012 Chesapeake Crematory Beltsville, MD 21. Sign we of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413, Baltimore, MD 21203 eanita 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Adenocarcinoma Immediate Cause (Final Ph_sician/ Sophagea disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine Due to (or as a consequence oi): if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed 2 No Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 M No ပ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Many er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending s after death.

I Director: Af
d in by the fu Investigation 2 Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours at To the Funeral D completed filled in Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist ar's Signature

Ulicks

31. Date filed (Month, Day, Year)

10y 27, 2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 012 12:12A M 25, Physician/ Sessa May Tillie Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Edgemere 2708 6th Street g. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) Social Security Number ^{Year)} 1924 Days **Funeral** Hours August 22 1 □ M 2 🛛 F Months Maryland 217-12-7782 87 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County 10a. State at Director 1 Yes 2 No 27 is marked other than "natural", or items 23a or 28a-f's traumatic event, the Medical Examiner must be notified Edgemere Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21219 Funeral 2708 6th Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 Never Married 2 Married] Yes 2 ☒ No þ Page 1 and 2 should be filed within 72 hours after onent of Health and Mantal Hygiene. ant: If item 27 is marked other than "natural", or White 1 ☐ Yes 2 🔀 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give 3 Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Hohns Bakery Baker 12 years 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Agnes Jondo ပ္ Felix Jondo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2708 6th Street, Edgemere, Maryland 21219 Kay Sessa Daughter item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of May 29, 20a. Method of Disposition cemetery, crematory or other place)
Oak Lawn Cemetery permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland 2012 4 Donation 5 Other (Specify) Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. Signature of Flungral Service License 7110 Sollers Point Road, Dundalk, Part 1. Enter the disea e, c complications that caused the dearn. I o not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final monai Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical mic Cardiowopath Examiner 18chem Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last a consequence of): Examine Due to (or as Car To the Hospital or Attending Physician: The law requires that the death certificate be executed and I-transit Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Fctopic pregnancy Month Year in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death 9 Unknown been signed by the a should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate has 26. Place of Death (Check only one) 25. Was case referred to medical filled in by the funeral director, To Be Other: Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 2 No 28b. Time of 28c. Injury at 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) Signature and title 2012 who completed cause of death (Item 23a) (Type, Print) address of po

State

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filed (Month, Day,

3 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9 : 54PM Donna Marie Schmidt MAY 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAL HOSPITAL OF BALTIMORE BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min Director 55 220-72-3156 1 □ M 2**X X**F March 8,1957 Massachusetts Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Tes 2XXNo MD Baltimore Owings Mills ō 10e. Street and Number 10g. Citizen of What Country? id Mental Hygiene. marked other than "natural", or items 23a Funeral 21117 U.S.A. 921 Academy Ave. death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married XXMarried 1 ☐ Yes XXNo Specify: White 3 Widowed 4 Divorced Specify: Completed Year or Dates Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Patricia Adelong Manuel Matias and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 921 Academy Ave. Owings Mills, MD 21117 Health tem 27 Gary L. Schmidt / Husband permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
All Faiths
rematory & Chapel 1 ☐ Burial XXCremation 3 ☐ Removal from State CHIMD 5/29/12 4 ☐ Donation 5 ☐ Other (Specify) Manchester, MD 22. Name and Address of Facilit Ckhardt Funeral Chapel P.A. 21. Signature of Fundal Service Licensee Rul 11605 Reisterstown Rd. Owings Mills, MD2111 ine 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Cercbrai Hemiation Medical Due to (or as a consequence of) Examiner 6 days erebral Edema Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury 6days Intraventricular Hemorrhual as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month 5 Other (specify) Pregnant at time of death ed by the a detached f a ☐ Unknown 9 Unknown P.O. been signed be should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 2 No 1 Yes Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 \(\text{\subset}\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 🖳 No 1 Manatient 2 ☐ ER/Outpatient 3 ☐ DOA 욘 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending s after dec. ral Director: A' Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Jah. Jan 24 hou. Ne **Funeral Dis.** In filled in by determined Medical 29a. Certifier 🖹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nursu Practitioner To the basis of my more assistance and place, and success and place, and one to the cause(s) and manner stated To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Olchaul LES 000 May 27,2012 2401 W. Beweden 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSPITAL OF BALTIMORE BOLLINOR, MD BATHLEEN MD Olchance 31. Date filed (Month; Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Year Paul P Snead 8:24 PM May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dove House Westminster Carroll If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 🛣 M 2 🗆 F Director 220-18-7297 3/17/1926 MD 86 Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes XX No Carrol1 Mt. Airy MD ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 21771 USA 4364 Ridge Rd. items death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

Yes 2 No Black, White, etc. ò ģ 1 Never Married 2X Married filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1943-47 1 ☐ Yes 2 X No Specify. "natural" Completed Specify: 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Self-Employed Electronics Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant: If item 27 is more any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anthony Everett Snead Mabel Heldman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42943 Farmingdale Dr., Ashburn, VA 20147 Paula S. McKeever/Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 6/1/2012 Alphonsus Cem. Woodstock, MD Burrier Offeety Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res shock, or heart failure. List only one cause on such line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Duri to for each considerings of if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe, 1 Yes 2 No 3 Probably 4 Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes funeral director, 25. Was case referred to -dical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gentlying Numb Prantitioner: To the best of my included a death occurred at the time, date and place, and due to the cause(s) and manner stated Gentlying Numb Prantitioner: To the best of my included a death occurred at the time, date and place, and due to the cause(s) and manner stated Gentlying Numb Prantitioner: To the best of my included a death occurred at the time, date and place, and due to the cause(s) and manner stated Gentlying Numb Prantitioner: To the best of my included a death occurred at the time, date and place, and due to the cause(s) and manner stated Gentlying Numb Prantitioner: To the best of my included a death occurred at the time, date and place, and due to the cause(s) and manner stated Gentlying Numb Prantitioner: To the best of my included a death occurred at the time, date and place, and due to the cause(s) and manner stated Gentlying Numb Prantitioner: To the best of my included and place are stated as a death of the cause o (Check 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.				Removal from	n State	ce	ace of Dispo emetery, cren	natory or o	ther place			9/2012		ocation - Cit kesvi1			
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nding I ath. r: After	icate	 Manner of Death Natural Accident 	5 Pending Investigat		of Injury	Year)	28b. Time of injury	M 2	Bc. Injury work? 1 🔲 ۱			8d. Describe h	now injur	ry occurred			
or Atte	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determine	28e. Place		y - At hon (Specify)	ne, farm, stre	eet, factory	office	_	2	28f. Location (S City or Tov			Rural I	Route Number,	
	Medical	29a. Certifier 1 (Check 2	Certifying Pl	hysician: To the b	pest of n	ny knowle	dge, death o	ccurred at	the time,	date and pla	ace, an	d due to the ca	ause(s) a	and manner a	s state	d.	_
o the Hithin 24 or the Formplets	Me	only one) 3	☐ Certifying N	ree Practitione	r: To the	best of my	y knowledge,	death occi	irred at the	e time, date a	rred at and plad	tne time, date a ce, and due to t	he cause	e(s) and manr	er as st		ied.
F S F O		1	m)	Sente	Y	(1.)		D	0050	1054			290. Da	te signed (M		ay, rear)	
21		30. Name and address ANA SUR	PANTE N	o completed cau	se of de	ath (Item 2	23a) (Type, P	rint) VE	SY	<esvi< th=""><th>LL</th><th>E, ME</th><th>2</th><th>724</th><th></th><th></th><th></th></esvi<>	LL	E, ME	2	724			
State Registra	-	31. Date filed (Month	h, Day, Year) 0 2012	A 32. F	Registrar	's Signatu						1.12		, , , , ,			
		11111 0	A ma.e	Mary Town	100	1											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May John Francis Simanski, Sr. 27, 2012 12:00 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Center Towson Baltimore Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours (Month, Day, Year) **Director** 212-28-5831 1 XM 2 - F 86 Maryland April 21, 1926 Usual Residence of Decedent 28a-f shov at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director items 23a or 28a-r sr ner must be notified **Highlands** Sebring 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3810 Ponce de Leon Blvd. 33872 U.S.A. and 2 should be filed within 72 hours after death 1 Heath and Mental Hygiene. I em 27 is marked other than "natural", or items ther traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. WW II 1 Yes 2 X No 3 X Widowed 4 Divorced Specify. Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Foreman Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Simanski Vincent Helen Pondo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a John F. Simanski, Jr. 12201 Highgrove Ct., Reisterstown, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of IImportant: If ite
any injury or ot
once. 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Parkwood Cemeterv 5/30/12 Parkville, MD 21. Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Dau Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a conse vence of) Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the IF FEMALE nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Other (specify) Pregnant at time of death Year 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Uniknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? Yes 2 certificate Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 110 Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Wother (Specify) Director; After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 1 Natural iniury Accident filled in by the Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a

To the Funeral D

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year

State Registrar 31. Date filed (Month, Day

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Madeleine R. Seipp 28 2012 1:55 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Towson **Examiner** 4c. County of Death Gilchrist Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday **Funeral** 8. Date of Birth Hours (Month, Day, Year) 212-20-0554 Director 1 🗆 M 2 🗶 F 90 April 13, 1922 Maryland or 28a-f show 10b. Count 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10d. Inside City Limits Director MD. Baltimore Towson 1 🗌 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21286 800 Southerly Rd. #504 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗶 No Black White etc 1 Never Married 2 Married þ Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify If Yes, Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) traumatic event, the Administrative Baltimore Co.Govt. Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental marked o ည Corinne Fleury Raphe1 Henri Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a W. Stephen Seipp/ Son 217 Melancthon Ave. Lutherville, MD. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. Timonium, MD. 6-2-12 4 Donation 5 Other (Specify) 21. Signature of F / ral Service ^{22. Naruck^{Ad}Towson Facility}Funeral Home, 1050 York Rd. Towson, MD. once. 23a. Part 1. Enter the or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest st only one cause on each line. Approximate shock, or heart failure Interval Between Immediate Cause (Final disease or condition Onset and Death Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death signed by the at d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed' After this certificate funeral director, pag 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 340 ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending within 24 hours fiter death.

To the Funeral Director Al 1 🗌 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tij 29c. License number 29d. Date signed (Month, Day, Year) 71040 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST SULTE LIOS RALICHORE State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2012 E. June Stevens A M May 3:15 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 220-12-7636 1 □ M 2 🗓 F 85 June 20. 1926 Usual Residence of Decedent Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 Yes 2 No Cockeysville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 10518 Lakespring Way 21030 USA Was Deceus.
Armed Forces?
Vas 2X No 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify 3 ♥ Widowed 4 □ Divorced white 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, James B. MacDermott, Sr. Ethel E. Mevers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah E. Adams daughter 10518 Lakespring Way; Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3

Removal from State Other (Specify) 4 Donation Dulanev Vallev Mem Gardens 6/1/2012 Timonium, MD 21. Signature of Fure 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can on each line.

Physician/ Medical Examiner

Physician/

Medical

Examiner

Funeral

Director

show

28a-f

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ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be

and Mental Hygier is marked other

Department of Health a Important: If item 27 is any injury or other trat

Baltimore, Maryland 21215-0036

3:15 a.m.

2012

ETHEL STEVENS

P.O. Box 68760

Hospital or Attending Physician: The law requires Division of Vital Records,

notified at

Director

Funeral

þ

Completed

Be

ည

examiner?

1 Yes

27. Manner of Death

1 X Natural

Accident

Suicide

29b. Signature and title of

4 Homicide

29a. Certifier

2 X No

5 Pending

30. Name and address of person who completed cause TRACIE L. MORGAN, CRNP

Investigation 6 Could not be

determined

Exami attending physician and for use as the burial-trai Physician/Medical been signed by the sahould be detached ò Completed cate has page 2 certificate Be 2 Certificate: n 24 hours after death.

le Funeral Director: Al oletely filled in by the fu

Medical

shock, or heart failure. List of	only one caff on each line.			Interval Between
Immediate Cause (Final disease or condition resulting in death)	a. DEMENTIA Due to (or as a consequence of):		-	Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
	d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of delive Month	ery Day Year
Part II. Other significant condition	ons contributing to death but not resulting in the underlying cause given in Part I.	1	use contribute to th	e cause of death?
		24a. Was an autopsy performed?	prior to con death?	osy findings available mpletion of cause of
25. Was case referred to medical	26. Place of Death (Check	only one)		

Other:

28c. Injury at

work

29c. License number

1 🗌 Yes

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

2 No

ed at the time, date and place,

4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE

Location (Street and Number or Rural Route Number,

28d. Describe how injury occurred

City or Town, State)

TIMONIUM, MD 21093

DHMH 17 Rev 06-2011

State Registrar

within 2

To the F

2300 DULANEY VALLEY RD.

1 Inpatient 2 ER/Outpatient 3 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

of death (Item 23a) (Type, Print)

28b. Time of

28a. Date of injury (Month, Day, Year)

3 X Certifying Nurse Practitioner: To the best of my knowledge

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death D2/012 May Month 20, Physician/ 12:56A Madalene Scrimger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Catonsville Manor Care at Woodbridge Valley Birthplace (State or Foreign Country)
 MD 8. Date of Birth Feb. 23, Year 1923 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours MD 217-18-9305 1 □ M 2 🗓 F Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director 1 🗌 Yes 2 💢 No Baltimore MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21236 4206 Winterode Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 X Married Yes ģ 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 White If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Telephone Telephone Operator Be 18. Mother's Name (First, Middle, Maiden Surname) filed 17. Father's Name (First, Middle, Last) and Mental မ Lena Belser Victor Buhl other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Inportant: If item 27 is many injury or other traumsonce. 19a. Informant's Name/Relationship (Type, Print) (son) 9510 Dundawan Road, Perry Hall, MD 21236 Mr. Albert M. Scrimger, Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Lake View Mem. Park | 5/23/2012 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 21. Signature of Funeral Service Licenses MO0764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPERTENSIVE CARDIDVASCULAR DISEASE
Due to (or as a consequence of): Planucian/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): the burial-transit Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ф in the past 12 months? Month Pregnant at time of death 5 Other (specify) signed by the at ild be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by THRO MBOSIS VEN OUS 1 Yes 2 No 3 Probably 4 Inknown peen 24b. Were autopsy findings available prior to completion of cause of death? CEREBRAL VASCULAR 24a. Was an autopsy performed? To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has I completely filled in by the funeral director, page 2 s 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 \square Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number Do059107 05-21-2012

State

Registrar

CENTER DRIVE

REISTERSTOWN, MD 21136

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

210

KALU UMA

MAY 3 0 2012

31. Date filed (Month, Day, Year)

BUSINESS

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 23, 2012 2:17 A M Mark SHALOM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 01 ney Montgomery Medstar Montgomery Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours (Month, Day, Year) 364-42-0928 90 1 X M 2 □ F Director Sept. 4, 1921 England Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 X No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20814 United States 5225 Pooks Hill Road #104N Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner m Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: Specify: white Completed 3 Widowed 4 Divorced than "natura the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Electrical Engineer Engineering marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F Bahie Tawil ဂ္ဂ Jacob Shalom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5225 Pooks Hill Road, #104N, Bethesda, MD item 27 Sabina Shalom, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Sther (Specify) Lebanon Cemetery 05/25/2012 Adelphi, MD 平orchinsky Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1 the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory 2051 disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** tracrania Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Se Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical measure Box 68760 the. as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death g Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 110 1 Nonpatient 2 ER/Outpatient 3 DOA ျှ 4 Nursing Home 5 Residence 6 Other (Specify) e Hospna, -... 1. 24 hours after death.
he Funeral Director: After th 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) 5 Pending work? 1 Yes 2 No M 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Pwithin 24 only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 2,3 12 006787

DHMH 17 Rev 06-2011

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State Registrar Manohar K.

31. Date filed (Month, Day, Year)

M.D., 7411 Riggs Road, Ste. 304, Adelphi, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chenchugalla,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 25. Melanie Sue STRUDLER 2012 9:57 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Silver Spring Montgomery 801 Kersey Road Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 154-36-2145 Director 1 🗆 M 2 🔀 F New Jersey March 9, 1951 61 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral 20902 United States 801 Kersev Road within 72 hours after death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Race - American Indian. Armed Forces?

1 Yes 2 No or i Black, White, etc 1 Never Married 2 Married ò 1 Yes 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: white 3 Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anne Spiegel Jerome Darvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 801 Kersey Road, Silver Spring, MD <u>Lewis Strudler, Husband</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Uudean Memorial Gardens 05/29/12 Olney, MD Torchthsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ Metastatic Pancreas Cancer disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Day Year Month Pregnant at time of death by the a g 🔲 Unknown q I I Inknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 page performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' Hospital 2 💢 No Other: 1 Yes ျှ 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Xvatural Accident 5 Pending n 24 hours after death.

Le Funeral Director: Af olderely filled in by the fundamental filled in by the 1 Tes 2 🗌 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24

To the F

complet Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title

State Registrar Rd., NW

Washington, DC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Marshall, MD 3800 Reservoir R

31. Date filed (Month, Day, Ye

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 16, Physician/ 2012 1120 ам Thomas Allen Smith Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a University of MD Medical Center Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MSountry) Months Hours 1070471966 45 086-58-5604 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is anaked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director Brooklyn NY n/a 1 Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 110 Weirfield Street 11221 . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Facility Mgmt Security Guard Be 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Linda Covington Thomas Allen Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Peyton Place Apt 5206 Atlanta, GA 30311 Linda Barrow / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Bushy Park Cemetery 5.25.2012 Cooksville, MD Donation 5 - Other (Specify) Funeral Service L 22. Name and Address of Facility
John L. Williams Funeral Directors, P.A. 4517 Park Heights Ave Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Par 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final distase or condition Intracerebral Hemorrhage Phylician/ Medical resulting in death) Due to (or as a consequence of) Examiner Seven Aneurysms 12 Days Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a consequence of Exami and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) hed t the 9 Unknown signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy performer 24 hours after death.

Funeral Director: After this certificate 1 ☐ Yes 2 🙀 No Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 Tes 2 No ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred Natural Accident injury 5 Pending 2 No Investigation Suicide 8 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 101705 May 16, 2012 Le, MD

Registrar

DHMH 17 Rev 7/2009

State

22 South Greene Street Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elizabeth J. Le

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Roland Lamar Smith 1107 M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Carroll Hospital Center Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 M 2 🗆 F Jan. 25,1925 Months Hours Min 87 219-20-0034 Maryland Director Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Carroll Manchester Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21102 U.S.A. 5312 Hoffmanville Rd. items 2 12. Was Decedent Ever in U.S. Armed Forces?

1 Xyes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3√ Widowed 4 □ Divorced If Yes, Give Year or Dates WW II White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Operator Heavy Equipment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Smith Bessie Shaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, f Health Karen Martin - daughter 1700 Northview Dr. Hampstead, MD. 21074 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit, Page 1 a
Department of H
Important: If ite 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lutheran Cem. May 29,2012 Manchester, 22. Name and Address of Facility Eckhardt Funeral Chapel P.A 21. Signature of Funeral Service Licenses Charmil Manchester, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ PULMONARY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be c 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 performed? Yes 2 N certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2-1 No ပ္ 1 Yes 1-☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check To the lawithin 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Mopth, Day, Year) DO059552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 121 TOOK POOLE RD WESTMINSTER MD 6-04RISHAMAR MOANMA 32. Registrar's ignatur 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0.5 07 Day 201 201 Ronald Smith 8:10р м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/Á Baltimore Anatomy Board 5. Social Security Number 213-70-1706 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 10/07/1959 Hours Min. Director 1 XM 2 □ F Maryland 52 item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evariner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits N/ABaltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 706 E. 41st Street 21218 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 5 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No Specify: 3 Divorced If Yes. Give Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " more, Maryland 2121 Elementary/Secondary (0-12)
12th Grade College (1-4 or 5+) Self Employed Landscaping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Veloise Wallace Johnny Smith permit. Page 1 and 2 shoul Department of Health and I Important: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 E. 41st Street, Baltimore, MD 21218 Catrina Taylor(niece) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🕏 Cremation 3 ☐ Removal from State 5-11-12 Injury o Baltimore, MD 4 Dopation 5 Other (Specify) on-site Crematory ture of Funeral Service License Joseph Home PA MD21217 2140 N. Fulton Ave., Baltimore, 5 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on used line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examin The law requires that the death certificate be executed attending physician and for use as the burlal-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month page 2 should be detached 9 Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 1 No 3 Probably 4 Unknown 24a. Was an 4b. Were autopsy findings available prior to completion of cause of After this certificate has perform death? 1 ☐ Xes 2 ☐ No Yes 2 No or Attending Physician: after death.

Director: After this certification by the funeral director. 25. Was case referred to hedica Be 26. Place of Death (Check onfy one) 2 No Hospital 1 Yes Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a Date of injury (Month, Day, Year) 27. Man of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Investig n
6 Cou t be
d ined Accident 1 Tes 2 🗌 No 3 Suicide filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral L Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner asystated. Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Margaret M. Tyler 2012 May 10:15 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Golden Crest Assisted Living Hampstead Carroll County 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 XX 96 Months January 12, 1916 Director 235-14-0741 Pennsylvania Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Carroll Hampstead 1 Yes 2 XXNo 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 18233 Gunpowder Road 21074 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) I Hygiene. Grace United Methodist Elementary/Seconday (0-12) College (1-4 or 5+) Sanitation should be filed with and Mental Hygien is marked other the Church Be event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Matthew Bidish Mary Veronica Kubica other traumatic Jermit. Page 1 and 2 st.
Department of Health an.
Important: If item 27 is m
any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Kaminski. - Daughter 18233 Gunpowder Road, Hampstead, Maryland 21074 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State May 30, 2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cardens of Faith Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel and Cremetion Services - Monkton 16924 York Road, Monkton, Maryland 21111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 2 Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed (Disease Or imjury and -trans that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 attending p yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2XXNo Month Dav Year 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2X 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an aw has autopsy performed? Yes 2 No. of Vital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? မ 2**XX**No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XXNatural Division s after death.
I Director: Aft
d in by the fur 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours aff To the Funeral Di completed filled ir Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of Jr. 30. Name and address of person no completed cause of death (Item 23a) (Type, Print) Business Center

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Marylan		artment of F		nd Mental Hy	rgiene Reg. No. 201	2 69
		Decedent's Name (First, Middle, 1)	Last)	•			2. Date of De	eath	3. Time of Death
Physicia Medi		Pauline M.					May 23	3, 2012 Yea	12:15 A ^M
Examir	er	4a. Facility Name (if not institution, g			4b. City, Town, or	Location of	Death	4c. County of De	
Funeral		Crofton Care & R 5. Social Security Number	Kehab Center B. Sex 7. Age (In yrs. le	ast birthdav)	Crofton If Under 1 Year	If Under 2	4 Hrs. 8. Date of Bir	Anne Ar	unde l Birthplace (State or Foreign
Director		423-09-1964	1 D M 2 X F	Yrs.	Months Days	Hours	Min. (Month, Da	ay, Year) (Sountry)
now tt	Ļ	Usual Residence of Decedent 10a. State 10b. County	95	y, Town or Loc	ation		√an. 5,	, 1917 AT	a bama 10d. Inside City Limits
lanylar Sa-fsh iffied	Director				Jan 1911				1 X Yes 2 No
the M or 28	į	Maryland Anne A	<u>runde i joro i</u>	ton	10f. Zip Code			10g. Citizen of What (Country?
n with 1s 23a nust b	Funeral	1922 Harcourt Av	enue		21114			USA	
r death		11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origi n, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ar Black, Wh	nerican Indian, ite. etc.
21215-0036 within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f shoe than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates.	1	☐ Yes 2 No	Specify:		Specify: Wh	
5-0 Phour	Completed	15. Decedent' (Specify only highest	s Education		lent's Usual Occupa		of warding	16b. Kind of Busines	
thin 7% than 1% the Me	,om	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do	O NOT use retired)	ianng most t	of working		
d 20 Hygie other ent, th	Be C	17. Father's Name (First, Middle, Las	st)	<u> Clerk</u>		18 Mother	's Name (First, Middle,	Hotel Maidan Surnama	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam once.	은	Floyd Miller, Sr.	•				rine Hury	, maiden damame)	
lary		19a. Informant's Name/Relationship		19b. Mailin	g Address (Street a			er, City or Town, State, 2	Zip Code)
and 2 sund 2 sund 2 sund 2 sund 27 sun 27 her tr		Stella Ann Morar				Avenu	e Crofton,	MD 21114	
imore Page 1 ament of Hanni If ite		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	emetery, cren	sition (Name of natory or other plac		Date	20c. Location - City	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lic			Crematory		/31/2012	<u> Waldo</u> Evans Fune	rf, MD
Bal permi Depar Impor any ir		> SELPK	nes					e, MD 2071	
		23a. Part 1. Enter the disease, or co shock, or heart failure. List onl	omplications that caused the deatly one cause on each line						Approximate Interval Between
Physician/		Immediate Cause (Final disease or condition	_a Carc	luc	tony	tono	(Onset and Death
Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	- (
	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	uence of):					
ransit	Examine	Cause (Disease or injury that initiated events	С						
te be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):					
Lords, P.O. Box 68760 Iaw requires that the death certificate be executed as been signed by the attending physician and e 2 should be detached for use as the burial-transi	edical		d						
ords, P.O. Box 6876 requires that the death certificat been signed by the attending ph should be detached for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar					23d. Date of c	elivery
Box death c the atten	sicia	in the past 12 morths? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown		Other (specify)	У		Month	Day Year
P.O. that the ned by the e detach		9 ☐ Unknown Part II. Other significant conditions		ulting in the u	derlying cause giv	en in Part I	OO - Did A	obacco use contribute	ha Alba a sura a fi da sala O
S, P	d by	faul	ue to the	د ما الما الما الما الما الما الما الما	racity mg caaco giv				Probably i 4 Denknown
Ord v requ	Completed						24a. Was		utopsy findings available
Vital Records, ysician: The law requires is certificate has been sig director, page 2 should b	omi						auto perfo 1 \(\sum \) Yes	ormed? death?	es 2 No
tal R	Be C	25. Was case referred to medical examiner?	I.		26. Pla	ace of Death	(Check only one)	101	es 2 🗆 140
Physic Physic this co	욘	1 Yes 2 No	Hospital:			4 Nurs	sing Home 5 Resid	dence 6 Other (Spe	ecify)
DIVISION OF tal or Attending PI rs after death. al Director: After th ed in by the funera	cate	1 Natural 5 Pending 2 Accident Investigat	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work? M 1			now injury occurred	
Atten Atten er dea ector: by the	Certificate:	3 Suicide 6 Could no	t be 28e. Place of Injury - At ho			163 2 1		Street and Number or F	ural Route Number,
DIV tal or rrs afte al Dir			Duliding, etc. (Specify)				City or Tov		ļ.
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check 2 \(\subseteq \text{Medical Exa}	hysician: To the best of my knowle miner: On the basis of examination	n and/or investi	gation, in my opinio	n, death occi	urred at the time, date a	and place, and due to the	e cause(s) and manner stated
Fo the within Fo the comple	Σ	only one) 3 ☐ Certifying N 29b. Signature and title of certifie	use Practitioner. To the best of m	ny knowledge,	death occurred at the 29c. License		and place, and due to t	the cause(s) and manner 29d. Date signed (Mon	
			V		D570	528		MAN 2	3,2012
2		30. Name and address of person wh	o completed cause of death (item	23a) (Type, Pr	rint) O' a O T) M-	1200000	1000 7111	11
<i></i> ✓ Stat		31. Date filed (Month, Day, Year)	32. Registro s Sign	1 MC	JIT 23	111	nyons	111V 214	U/
Stat Registra	_	MAY 3 0 2012	Cenna B. A	and I					
DHMH 17 Pay 06-3									

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

1	For State Registrar			laryland / I		ate of Dea			Reg. No.	20	12	16	59
n/		ne (First, Middle, Las	st)					2. Date of De Month	eath Day 26	¥ 3	Year	3. Time	
al er		Jrevich if not institution, give	street and number)		4b. C	ity, Town, or Loc	cation of Death	May		County of	012	6:40) <u>F</u>
	Hebrew H	-lome				Rockvi			10.	Mont		erv	
	5. Social Security N			ge (In yrs. last birt	hday) If Un Month	der 1 Year If	Under 24 Hrs. lours Min.	8. Date of Bir (Month, Da				lace (State	or Fore
	218-92-5 Usual Residence		□ M 2 🔀 F	93	Yrs.			July 3	3, 19	18	Rus	sia	
후	10a. State	10b. County	<u> </u>	10c. City, Tow	n or Location	• • • • • • • • • • • • • • • • • • • •		1			1	0d. Inside	City Lin
Director	MD	Montgo	omery			Rockvill	Le					1 🗓 Ye	es 2
	10e. Street and Nu		"-		10f.	Zip Code				izen of Wh			
Funeral	6060 Ca.	lifornia (Circle #30		13. Was Dec	20852 cedent of Hispa		ecify Yes or No-		i.ted 14. Race -			
by F		ried 2 Married	Armed Forces? 1 ☐ Yes 2 ☑)	If Yes, s	pecify Cuban, N	lexican, Puerto				White,		
	3 X Widowed	4 Divorced	If Yes, Give Year or Dates.		1 L Yes	s 2 🗙 No S	pecify:			Specify:	Whi	.te	
ompleted	(Sp	15. Decedent's E ecify only highest gr		16a	(Give kind of	sual Occupation work done durin		ing	16b. Ki	ind of Busi	iness/Ind	dustry	
S	Elementary/Sec	condary (0-12)	College (1-4 or 5+		iife. DO NOT: entist	use retirea)			Der	ntal	Heal	thcar	<u></u>
	17. Father's Name	(First, Middle, Last)			0110100	18	. Mother's Nam	e (First, Middle,			11003	·	
잍	Lazar I	Derbaremd:	icker			נ	Tuba S	ilberman	n				
		lame/Relationship (7	ype, Print)	19b	. Mailing Addr	ess (Street and	Number or Run	al Route Numbe	er, City or	Town, Sta	te, Zip C	ode)	
	Yakov (20a. Method of Dis	Jrevich /	Son		060 Cal		-	= #303 1					52
	1 🗌 Burial 2	X Cremation 3 □	Removal from State	e cemete	ry, crematory o	r other place)	i	Date		cation ~ C	-		
		5 Other (Special		Final J	ourney	and Address of	Pry 5/25	9/2012				Mary]	Land
	1/200	uh L	Ho lito	MO125	Going 1 Bever	Home C	remation Jeckroti	on Servi	ice I Cla	P.O. arksv	Box i 11e	784 - MD	210
П	23a. Part 1. Enter shock, or hea	the disease, or com	plications that cause	ed the death. Do r								Approxima Interval Be	ate
	Immediate Cause disease or conditi	(Final on		ENTIA							,	Onset and	Death
	resulting in death)		а.	a consequence	of):							1	
-er	Sequentially list or if any, leading to it		b. Due to (or as	a consequence	off:						+		
Examiner	Cause (Disease or	erlying r injury	500 10 (6) 40	a consequence	01).								
	that initiated even resulting in death)		Due to (or as	a consequence	of):						\top		
dical		•	d										
	IF FEMALE:		00-16										
cian,	23b. Was deceden in the past 12	months?		e of pregnancy 2 Fetal deatl at time of death	3 🗆 Ectop	ic pregnancy			1	23d. Date Montl		ry Day	Year
Physic	1 Yes 2		9 Unknown		5 🗆 Olliei	(specify)							
by P			ontributing to death		,		n Part I.	23e. Did t	obacco u	se contrib	ute to th	e cause of	death'
edt	UPPER	STROIN	TOTINAL	HE MO	RRHAG	E		1 🗆	Yes 2	□ No 3	Prob	ably 4	Unkr
Completed								24a. Was				sy findings	
Sol								perfo	ormed?	dea	ath?	2 🗆 No	
m	25. Was case reference examiner?		Hospital:			1	of Death (Chec	k only one)					
은	1 Yes 25	No th	1 Inpat	tient 2 ER/Ou	Itpatient 3 Fime of	DOA Other: 4		ome 5 Resid					
Certificate:	1 Natural 2 Accident	5 Pending Investigation	(Month, Da		njury M	work?	2 🗆 No	28d. Describe h	now injury	occurred			
制	3 Suicide 4 Homicide	6 Could not b	28e. Place of In	jury - At home, fa	rm, street, fact	ory, office		28f. Location (S		Number (or Rural	Route Num	nber,
1 20 1			building, e	tc. (Specify)				City or Tov	vn, State)				
	29a. Certifier	2 📖 Medical Exam	sician: To the best o	examination and/o	or investigation,	in my opinion, d	eath occurred a	t the time, date a	and place,	and due to	o the cau	se(s) and m	nanner
	(Check		se Practitioner: To the	ne pest of thy kno					00-1 D-4	1 /	A de cable - C		
Medical	only one)	title of pertifier	1	0	4	29c. License nur	nber		Zou. Date	e sidilida li	Month, [lay, rear)	
Medical	only one)	title of pertifier	Feet M.	D-		196. License nur	1787		5/3	27/1	2	ау, төаг)	
Medical	only one)	title of pertifier	completed cause of Completed Cause of Completed Cause of Completed Cause of Complete Cause of	death (Item 23a) (Type, Print)		1782	~ MD	5/2	17/1	2	oay, rear)	

DHMH 17 Rev 06-2011

•	For State Registrar	State of M	aryland / Depa		ealth and M	lental Hygi	•	2 16913				
Physician/ Medical Examiner	Decedent's Name (First, Middle Robert Record of the Record of	Vesc	husio	4b. City, Town, or L	ocation of Death	2. Date of Death Month	Day Yea 26 20	2 08 AM				
Funeral Director	5. Social Security Number 529-50-0733 Usual Residence of Decedent	ington Medical 6. Sex 1 M 2 D F 7. Ag	Cente e (In yrs. last birthday) 75 Yrs.	If Under 1 Year	BVVL If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 1,	Anne A	Birthplace (State or Foreign Country) ew York				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10a. State 10b. Count Maryland Anne 10e. Street and Number 93 Berrywood 11. Marital Status	Arundel	10c. City, Town or Lo		onio Origina (Cro	Ţ	0g. Citizen of What United St					
within 72 hours after dealiene. r than "natural", or ite the Medical Examiner Completed by Fi	Armed Forces? 1 Never Married 2 Married											
nould be filed wi nd Mental Hygie s marked other umatic event, ti To Be (17. Father's Name (First, Middle Cristie Vesch: 19a. Informant's Name/Relation	usio			18. Mother's Name	e (First, Middle, Milliams	aiden Surname)					
Page 1 and 2 st ment of Health a lant: If item 27 is ury or other trai	Rosario A. Ves 20a. Method of Disposition 1	n 3 🗌 Removal from State	20b. Place of Disponsemetery, crem	Berrywood	Dr., Sev	verna Par 29.	rk, Mary1 20c. Location - City	and 21146				
permit Depart Import any inj	21. Signature of Cheral Sarvice 23a. Part 1. Enter the disease, shock, or heart failure. Lis		the death. Do not ent	Name and Address irkley-Rud 21 Crain F	dick fur lwy., S.E		me, P.A. Burnie,	MD 21061 Approximate Interval Between				
Physician/ Medical Examiner Cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	a. Due to (or as Due to (or as Due to (or as	a consequence of):	infanct the ster van	ion Novis			Onset and Death				
at the death certificate by the attending physetached for use as the Physician/Medii	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1	2 Fetal death 3	Ctopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year				
The law requires that the sate has been signed by page 2 should be detac	Part II. Other significant condi	tions contributing to death b	out not resulting in the u	underlying cause give	n in Part I.		s 2 No 3 2	to the cause of death? Probably Unknown autopsy findings available to completion of cause of				
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the Medical Certificate: To Be Completed by Physician/Medi	3 Suicide 6 Cou	Hospital: 1 Inpati 28a. Date of inju (Month, Day stigation d not be	ent 2 ER/Outpatie ry 28b. Time or injury	ont 3 00A Other:	es 2 No	perform 1 Yes 2 conly one) me 5 Resider 28d. Describe how	nce 6 Other (Sp.	? Yes 2 No				
To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b Medical Cel	29a. Certifier 1 Certifyi (Check 2 Medica	building, etc ng Physician: To the best of Examiner: On the basis of e ng Nurse Practioner: To the ter	my knowledge, death xamination and/or invest best of my knowledge,	occured at the time, o	late and place, and death occurred at ime, date and place	City or Town, d due to the caus the time, date and e, and due to the c	e(s) and manner as d place, and due to the cause(s) and manner	stated. ne cause(s) and manner stated as stated.				
State Registrar	30. Name and address of person Nna-cun A. 31. Date filed (Month, Pay, Year, 31. A. 3	n who completed cause of dailed MD 44	eath (Item 23a) (Type, I Madison ar's Signatu)			Oten G	May 24 Imie A	ND 21061				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 23ª Ruth Wampler Valentine May 2012 10:20P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Taneytown Carroll Country Companions Assisted Living 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav **Funeral** Hours 220-28-8413 Director 1 M 2X F 98 MD Apr 17, 1914 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗌 Yes 2 💢 No MD Carroll Keymar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6930 Keysville Road 21757-9609 USA death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 \square Yes 2 \square No If Yes Give Specify 3 Widowed 4 Divorced Completed Year or Dates. White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 10 Food Preparation Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Herbert D. Wampler Millie Bushey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 2523 S. Baumgardner Rd., Keymar, MD 21757 Mr. Mike Bollinger (Co-executor) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Keysville Union Cem. 6/1/2012 Keysville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Signature of Funeral Service Licensee PO Box 195 Sykesville, MD 21784 Hund 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Medical DEBILIT resulting in death) (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to tot as a consequence on burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last physiclan Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 as the the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) signed by the a ld be detached f 2 NO 1 Yes 2 L 9 Unknown Hospital or Attending Physician: The law requires that the 24 hours after death.
Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes D LUY O PATTA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 Yes 2 No Yes 2 No in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Spe 2 1 No 1 🔲 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral C completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signatu

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	1	For State Registrar			Cei	tificate of D	Death		Reg. No. 2	012 16		
/sician/	/	1. Decedent's Name (First, Middle, Elizabeth Wilse	,					2. Date of Dea Month May 9,	Day 2012	3. Time of De Year 8:00 E		
∕ledical aminer	-	4a. Facility Name (if not institution, g		ber)		4b. City, Town, or	Location of Death	1147 7		y of Death		
		1902 Treeline	Drive			Fores	t Hill		Har	rford		
eral	1			7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	n , Year)	Birthplace (State or F Country)		
ctor		218-14-7653 Usual Residence of Decedent	1 □ M 2 💢 F	78	Yrs.				, 1934	Maryland		
g at	5	10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City		
tiffied	<u></u>	MD Harfor	:d		Fore	st Hill				1 ☐ Yes 2		
er must be notified at Funeral Director	5	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Country?		
nust		1902 Treeline D	rive				1050		US	SA		
iner r		11. Marital Status	Armed For	dent Ever in U.S ces?	5. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - American Indian, ack, White, etc.		
xam d b	2	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give	,		Yes 2 🗶 No	Specify:		Specify	y: white		
the Medical Examir Completed by		15. Decedent		tes.		dent's Usual Occupa		unk	16b. Kind of E	Business/Industry		
Med med	┋├	(Specify only highest Elementary/Secondary (0-12)	college (1-	4 or 5+)		kind of work done d O NOT use retired)	during most of work	ing		•		
t the	3	12	O						Baltim	nore Sunpaper		
c event,	5	17. Father's Name (First, Middle, La					18. Mother's Nam			,		
тапс	H	Leo Randolph Re			T			Marie				
		19a. Informant's Name/Relationship		_		ng Address (Street a						
ther		Debbie Schmidt 20a. Method of Disposition	./ daugnte			Treeline	-	orest H:		21050 - City or Town, State		
any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		1 Burial 2 Cremation 3 4 N Donation 5 Other (So	Removal from			natory or other plac	:e)	Date	20c. Location	- Oily of Town, State		
any in		21. Signature of Funeral Service Lic Bonal of S 23a. Part 1. Enter the disease, or c	Nage 1							imore Street		
ical examiner		disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (d	or as a consequence as a consequence or a consequence or a consequence								
Physician/Medic	ily sicially mea	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 ☐ Pregr 9 ☐ Unkn	Birth 2 Feta pant at time of co own	leath 3 [Ectopic pregnanc Other (specify)	ate of delivery conth Day Yea					
<u>a</u>		Part II. Other significant condition				, ,	en in Part I.			atribute to the cause of deal		
page 2 should be detached for use as the Completed by Physician/Medii		Chronic Obstit	ne five	u yrong	19 00	seeme,						
	Chronic Obstructive Pulmonary disease, 1 × Yes 24a. Was an autopsy performed 1 × Yes 2 × 1									Were autopsy findings ava- prior to completion of cau- death? 1 Yes 2 No		
Complete	3 L						ace of Death (Chec	k only one)				
Be Complete	3	25. Was case referred to medical examiner?	Hospital:		ER/Outpatier	_	4 L Nursing Ho	ome 5 🗷 Resid				
To Be Complete	2	examiner? 1 ☐ Yes 2 🕱 No			00h Ti							
ificate: To Be Complete	2	examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investige	28a. Date of (Mont)	of injury h, Day, Year)	28b. Time of injury	M 1 🗆	?					
Certificate: To Be Complete	oci micare: 10 pe	examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of (Monts)	of injury h, Day, Year)	injury me, farm, str	work	?		treet and Numb	ber or Rural Route Number,		
precely nired in by the luneral director, page z snot Wedical Certificate: To Be Complete	oci micare: 10 pe	examiner? 1 Yes 2 No 27. Manner of Death 1 No Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin 29a. Certifier 1 Certifying F	28a. Date of (Mont.) 28b. Place building	of injury h, Day, Year) of Injury - At hog, etc. (Specify est of my know) s of examination	injury me, farm, str) edge, death of and/or inves	work M 1 eet, factory, office coccurred at the time tigation, in my opinio	Yes 2 ☐ No e, date and place, a on, death occurred a	28f. Location (S City or Town and due to the ca t the time, date ar	treet and Numb n, State) use(s) and man nd place, and du	ber or Rural Route Number, nner as stated. ue to the cause(s) and mann		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WILLIAMS 2012 Medical 4a. Facility Name (if not institution, give street and number, Town, or Location of Death **Examiner** berly CO Id Mul 1 Year If Under 24 Hrs. If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 218-44-4786 **Director** 1 M 2 D F ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No timore 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21209 703 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 2 ☐ Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural". Completed 3 Widowed 4 Divorced lac Year or Dates permit. Page 1 and 2 should be filed within 72 houn Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 19a. Informant's Name/Relationship (Type, Print) City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or triciat. MD 21207 20a. Method of Disposition . Place of Disposition (Name of Commetery, crematory or other place, ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 0 disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence on sician and burial-transit Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) jo in the past 12 months? Month Dav Pregnant at time of death
Unknown] Yes 2 ☐ No been signed by the should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy 1 🗌 Yes 2 No __ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Warse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signa 10 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 02 : 49 PM Rebekah L. Wilkins Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimore Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 218-44-4849 **Director** 1 □ M 2X F 65 5**-**30-1946 MD Usual Residence of Decedent 28a-f show death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Funeral Director 1 Yes 2 X No MD Baltimore Pikesville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 1 Highstepper Ct. Unit 101 21208 USA 12. Was Decedent Ever in U.S. Armed Forces2 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African-American 1 Yes 2 XNo Specify. "natural", Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) R.N. Johns Hopkins Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ollie Wilkins Sr. Rosa Mae Hines other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traunonce. <u> Angela M. Morris/Daughter</u> 1 Highstepper Ct. Unit 101, Pikesville, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Ren oval from State Metro Crematory 5-30-2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lie Funeral Home P.A. of Balto. Co. ture Funera 9200 Liberty Rd., Randallstown, MD 21133 Part 1. Enter the disease, or complication shock, or heart failure. List only one can ne that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ mall cell carcinomo of the lung Metogratic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence oi). Exam Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: The law requires that the death ☐ Pregnant at time of death ☐ Unknown signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, sclerosis, Chronic Obstructive 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? disease 24a. Was an hypertension page 2 autopsy perform certificate 2 🗌 No Yes 2 No 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Other: 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE hours after death.

Ineral Director: After this is ly filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending work' 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Beliedere State

DHMH 17 Rev 06-2011

Registrar

MAY 30

Rebekah

Known as:

certificate be Division of Vital Records, P.O. Box 68760 Hospital or Attending Director

show

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Il Hygiene. I **other than** "

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Department of Health at Important: If item 27 is any injury or Att

Physician/

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page 2

director,

After this funeral,

Director: A did in by the f

altimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

29b. Signature and title of certifier

NSRajapakseMb

15 Rajapatre MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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12-03934 Doris Lilli Wells Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Doris L	illi Wells	;	1- For State Registrar	St	ate of Maryla		artment ertificate			Menta	l Hy		teg. No	20)	2	1691
Madia	Physic		1. Decedent's Nam		e,Last) Wells						2	. Date of Dea	ath				of Death
Medic	al Exam	ime	4a. Facility Name (i			ımber)		4b. Cit	y, Town, or L	ocation of I	Death	Month May 23, 2	2012	c. County of	Death		3 hrs
			1 Westway						eenbelt					Prince G			
	Funeral Director		5. Social Security N 214-82-8		6. Sex	7. Age (In yrs.	7		nths Days	If Under 2 Hours	24Hrs. Min.	8. Date of Bi		1	Foreign		State or ermany
	è		Usual Residence of 10a. State	Decedent 10b. County		Inc. Cit.	, Town or Lo	cation								10d Inc	ide City Limits
	ne Maryland or 28a-f show any fied at once.		MD		e George'		enbelt										es 2 No
	e Maryla or 28a-f	Director	10e. Street and Nur 1 Westwa		B	•			Zip Code				0g. Cit USA	izen of Wha	t Coun	try?	
	with th	ralD	11. Marital Status	y Offic	12. Was Dec	edent Ever in U		Was Dece	edent of Hisp			cify Yes or No		14. Race -	Americ	an India	n, Black,
	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mornell Hygiens. Department of Health and Mornell Hygiens are in the manual file in a marked other than "maintan", or items 33a or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once,	Funeral	1 Never Marrie		arried Armed For 1 Yes orced If Yes, Give Yes	2 X No			ecify Cuban, I		uerto Ri	ican, etc.)		White,		-e	
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		Physician/Me	past 12 months? 1 Yes 2 ✓ N		4 Pregna	ant at time of de	- =	Other (S] Estopis pit	og.iano			Werter		.,	, cai
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Division of Vital Records,	10 the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the i	Certification:	3 Suicide 4 Homicide		not be 28e. Place	of Injury - At he Single Fam			ry, office buil	ding, etc.		f. Location (S or Town, St Vestway Un	tate)			l Route I	Number, City
:	n 24 hou r 24 hou re Funer letely fil		29a. Certifier (Check only 1		rsician: To the best	of my knowledg	ge, death occ	urred at ti			and du	e to the cause	e(s) and	d manner as	stated		
	To the comp	Medical	29b. Signature and ti		Iner: On the basis o and manner st	ated.	nd/or investig		ny opinion, de 9c. License n		ed at th	e time, date a		ce, and due Date signed			
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(14		30. Name and addres		ho completed cause sistant Medical		•	Baltimo	e Street.	Baltimore	e, MD	21223					
	St Regist		31. Date filed (Month	, Day Year)		istrar's Signatu											

State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month : 40 PM **Physician** tor 2012 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year 8. Date of Birth (Month, Day, Year) May 29, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1 🔀 M 2 🗆 F Months Days Hours 219-07-4519 91 Maryland **Director** Usual Residence of Decedent 10d. Inside City Limits or 28a-f show notified at 10c. City, Town or Location 10a. State 10h Counts Md. Baltimore Dundalk 1 ☐ Yes 2 🔀 No Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? must be 7962 St. Monica Drive 21222 items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. "natural", or iten dical Exa⊞iner 1 Never Married 2x Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Seagram's Distillery Accountant 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic event, æ Teopil Waskiewicz Mary Sobczak မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Waskiewicz Wife 7962 St. Monica Drive, Dundalk, Md. 21222 Baltimore, May 29, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State Baltimore, Maryland Bayview Crematory 4 Donation 5 Other (Specify) ²² Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 21. Signature of Funeral Service Lice 101176 of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) esenter **Physician** hemia day /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) g physician and as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2 X No or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner?

1 Yes 2 No Hospital: 1 Inpatient Other: 4 \sum Nursing Home 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) ၉ this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 Accident Injury 5 Pending 1 Tes 2 No investigation 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (check only one) within 2 To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 avnka 0/0 31. Date filed (Month, Day, Year) State MAY 3 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

12-04036 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 16921 Walter Warnock State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day May 28, 2012 Year **Medical Examiner** Walter Warnock 0545 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year **Funeral** Foreign Country) Michigan Months Davs Hours Director 595-38-9740 1 XM 2 F 41 May 19, 1971 Yrs Usual Residence of Decedent 103 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 X No or 28a-f show Maryland Baltimore Dundalk "natural", nr items 23a or 28a-f shov Examiner must be notified at once, altimore, MD 21215-0036

mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
partment of Health and Mental Hygiene.
portant: If item 27 is marked other than "natural", or items 23a or 28a-f sho
ury or nather tranmatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7946 St. Bridget Lane 21222 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X Married If Yes, Giva Year 3 Widowed 1 Yes 2 X No specify: White Specify: 至 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Crane Operator Dreadge & Dock 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter M. Warnock Glenda S. Hearn 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia Gonzales Warnock wife 7946 St. Bridget Lane, Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, May 30, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Bayview Crematory 2012 Baltimore, Maryland 4 Donation 5 Other Specify. 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part I. Enter the disease of complication failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical Death a. Pulmonary Thromboembolism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Deep Vein Therombosis of Left Leg Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED attending physician for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 1 Yes 2 No 3 Probably 4 V Unknown pleted certificate has been s ector, page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Com ✓ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 24 hours after death. funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other₄ Nursing Home 5 Residence 6 Other: 2 FR/Outpatient 3 DOA this 1 🗸 Yes After 28a, Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 5 Pending 1 Yes 2 No I Director: Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Certifi 3 Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca (Chei 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

within

29b. Signature and title of certifier

Theodore M. King, Jr., MD

29c. License number

O.C.M.E.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

OCME

29d. Date signed (Month, Day, Year)

May 29, 2012

and manner stated

32. Registrar's Signature

30' Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 69 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ Day 201^{Year} 28 9:17 AM Russell Μ. Wedge, III Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist To<u>wson</u> 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year) Director 215-28-3612 1 🕅 M 2 🗆 F Oct. 24,1931 Maryland 80 Yrs Usual Residence of Decedent or 28a-f show notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2 🛣 No Timonium Baltimore Maryland 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o with 1 Funeral U.S.A. 21093 508 Limerick Circle Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces 1 X Yes 2 \square No If Yes, Give 1949 - 1951 Year or Dates. Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City n and Mental Hygiene.
7 is marked other than raumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Fire Department Fireman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth France Wedge Evelvn Russell Murrav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timonium, Maryland 21093 Department of Health Important: If item 27 any injury or other to once. Evelyn E. Wedge 508 Limerick Circle 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 6-2-2012 Maryland Towson 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21204 Towson, Maryland Cu 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Leath Physician P disease or condition . Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed the burial-trans and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has funeral director, page 2 autopsy performed? certificate 2 🗌 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \(5 \) Residence \(6 \) Other (Specify) \(\text{1 \text{Nursing Home}} \) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 2 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, value and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License numbe 29d. Date signed (Month. MD 7-1040

Registrar

DHMH 17 Rev 06-2011

State

4105

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

32

RATHIN. KN DUAR

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death cedent's Name (First Middle, Last) 2. Date of Death Physician/ Noel hard Medical e (if not institution, give street and number) **Examiner** 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 363-34-0891 Director 1 🛛 M 2 □ F 79 Jan. 10, 1933 Illinois or 28a-f shov 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 Is marked other than "natural", or Items 23a or 28a-f shortranmatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Washington DC 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20003 United States 146 - 11th Street, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygien of Item 27 Is marked other the U.S. Government <u>Attornev</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anne Armour Joseph J. Wolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Muriel DuBrow Wolf, Wife 146 - 11th St., SE, Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Lebanon Cemetery: 05/30/12 Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) For Ghanskys Hebrew Funeral Home Service Lidensee 20012 401008 254 Carroll St., NW, Washington, DC 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Natural 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie LIPSON, MD. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 21/12 William White Jr. 22 Ey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Washington Med.Center Glen Burnie Anne Arundel Co. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 219 – 30 – 1836 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Davs **Director** 1 XM 2 □ F 79 Yrs. 10/18/1932 Virginia or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? ms 23a or Funeral with 1 7806 Spencer Rd. 21060 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or edical Examin ò Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 ₩ Widowed 4 □ Divorced Black er than "natur , the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) 2nd Grade College (1-4 or 5+) Mason Cement Contracting is marked other aumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 127 is marked er traumatic e William White Sr. Annie White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tonya White(step Daughter) 7806 Spencer Rd., Glen Burnie, MD 21060 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important; If it any injury or o cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Zion Cemetery 05/30/12 4 ☐ Donation 5 ☐ Other (Specify) Mt. Baltimore, MD 21. Signature of Funeral Service Licenses JOSEPHAGHES OF BITTOWN Jr. Funeral Home PA 2140 N.Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

a. Cavaliac

AWWW BS Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to lor as a consequence of cause. Enter Underlying Exami Cause (Disease or injury signed by the attending physician and deededed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 s, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ L g ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 Yes Be 25. Was case referred to hedical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 1 Yeş 1 PInpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year 2012 30. Name and address of person who completed cause of death (Item 23) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

C

Uhite, W.

32. Registrar's Signature

12-03781	
Virgil White	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rgil White		State of Maryland / Department of For State Registrar Certificate of Certificate			Mental	Нуς		eg. No	20	12	16925
Physician edical Examine	1	1. Decedent's Name (First, Middle,Last) Virgil Rudolph White					Date of Deat Month May 17, 20		Year		Time of Death 2130 hrs
	ľ	4a. Facility Name (if not institution, give street end number) 1527 Clifton Avenue		city, Town, or Lo altimore	ocation of De		•		lc. County of D	eath	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1	M	Under 1 Year Months Days	If Under 24 Hours	Hrs. Vin.	8. Date of Bin	•	1935	. Birthpla oreign Country	1470
MD 21215-0036 nd 2 should be filed within 72 hours after alth and Martial Hygiene. numatic eveot, the Medical Examiner.	to be completed by Funeral Director	10e. Street and Number 1527 Clifton Ave. 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Nerried Forces? 1 New Note Store Year 1 Note Store Year 1 Note	1 to 100 100 100 100 100 100 100 100 100 10	dress (Street and Jew Free (Name of ceme)	anic Origin? Mexican, Pue specify: n (Give kind NO NOT use B.Mother's Na Elio and Number	of woretired	cify Yes or Notican, etc.) rk done irst, Middle, Ne Unk ral Route Num	U 16b.	White, e Specify: E Kind of Busin BGE n Surname)	Country: merican to. Slac ess/Indu	Indian, Black, k stry Code) D21122
Baltimore, Wermit Pages I at Department of He Important of He injury or other tr		21 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Card	n 40	Forest PriAddress of N. Fi node of dying, so	f Brillow: 11ton uch as cardia	n .	ve., I	nei Bal	cal Ho Ltimor	me e,	PA MD 21217 pproximate Interval letween Onset and Death
be executed ician and irial - transit	edical Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): AMENDED								-	
J. Box 68760, in the death certificate be executed by the attending physician and ached for use as the burial - transi	nysician/iv	past 12 months?		(Specify)	Ectopic pre	gnand			3d. Date of de Month o use contribut	Day	Year cause of death?
Records, P.O. The law requires that to ficate has been signed by page 2 should be detac	Completed by	Cancer, NOS				_	1 Yes 24a. Was autop perfor 1 Yes	an sy	24b. Wei	e autops	y 4 V Unknown sy findings available oletion of cause of 2 No
F Vital Physician: rr this certical director	10 De	25. Was case referred to medical examiner? 1		DOA O		ırsing	Home 5		dence 6 🗹 (Other: So	ene
Division To the Hospital or Attendit within 24 hours after death. To the Froeral Director: A completely filled in by the fi	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, stre (Specify)				\bot	or Town, S	tate)			Route Number, City
To the H within 24 To the Fr completel	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated. 29b. Signature and title of certifier	tion,	in my opinion, o 29c. License O.C.M	number	ed at t	the time, date	and p	and manner as place, and due I. Date signed	to the ca	
	-	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900				altim	ore, MD 21			•	
Star Registra		31. Date filed (Month, Day Year) 32. Registrar's Signature	1								

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town. or Location of Death 4c. County of Death Emmanuel icott Howard . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sex 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 M 2 N 92 Yrs. oved Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director llicott 1 Yes 2 No +oward 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ILSA 104 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in 1).S 11. Marital Status 12 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Asian Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene.
77 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) touse w omesti Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ $h \infty$ injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 2104 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health an
Important: If item 27 is 1 Son Bridge Ellicott (ames Bonny 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) traent tanover 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ho 1 NO 1 TOIC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a conseque ce of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician afor use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗹 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 2 No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred After t 1 / Natural 5 Pending 1 Yes Director: / Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) 29a. Certifier

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: npleted filled in by within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 31 Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 28^{ay} 2ď12 Marcaret Madeline Zulkowski 1:25 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford **Examiner** 2122 Franklin Church Road Darlington . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Ball timore Mary land 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Months Days Hours Min April 04. 212-26-9118 83 Yrs Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director Darlington Harford Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 72 hours after death with U.S.A. 21034 2122 Franklin Church Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. ed other than " event, the Med within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Fraction Teachers Aid 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e 1 and 2 should be filed of Health and Mental He item 27 is marked ot rother traumatic ever ၉ Reference Cecelia Davis Henry Charles Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2122 Franklin Church Road, Darlington, Maryland 21034 Mr. Michael C. Zulkowski (Son) Department of Health Important; If item 27 any injury or other the Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) cemetery, crematory or other place, Page ' June 02, 2012 Aberdeen, Maryland Harford Mem. Gardens Jeffrey R. 21. Sign 22. Name and Address of April & Cremation Services - Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 Testemen (M01543) 23a. Part / Enrepthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hart failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between y Candi A Ph_sician/ ent Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day 9 Unknown be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsv After this certificate 1 Yes 2 No Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending injury Accident Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 🛮 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. . Signature and title of certifier 29d. Date signed (Month. Day, Year) 0544 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2027 Pula ski Hwy. Registra's S Robert Rapp, MD 202 Havre de Grace State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 9:05 AM 26 Richard John Zubrowski 2012 0.5 Medical City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore Rosed Square Hospital . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 220-20-4222 **Director** 1 💢 M 2 🗆 F 85 March 10, 1927 Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State notified at Director 1 X Yes 2 No Maryland Baltimore City n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 7011 East Baltimore Street ial Hygiene. id other than "natural", or items event, the Medical Examiner m Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No 1945-1 Never Married 2 X Married ģ 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 1946 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Engineering Drafter Western Eletric Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H If item 27 is marked of r other traumatic ever ည John Zubrowski Pearl Cieslewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Gloria Mary Zubrowski/wife 7011 E. Baltimore Street Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Metro Crematory,Inc. 5/29/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland, Inc Stephanie Custer 299 Frederick Road Baltimore, Maryland 21228 3 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau, on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** + Ension Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or injury that initiated events resulting in death) Last and the burial-tra Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day 4 Pregnant 9 Unknown Pregnant at time of death 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an tate has by page 2 s autopsy 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 1 Natural injury 5 \square Pending work? 1 ☐ Yes 2 ☐ No after death. Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

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completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 26 use of death (Item 23a) (Type, Print) 30. Name and addre

Registrar

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Huyeung

9000 Franklin Square Dewe, Baltimore MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 11:55 P M BARBARA SIBERT ASHBURY Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth Hours Min (Month, Day, Year) 217-30-7183 1 🗆 M 2 🕮 F 76 Usual Residence of Decedent March 25,1936 Maryland 10b. Count 10c. City. Town or Location Director 10d. Inside City Limits Maryland Frederick Frederick 1 Tes 2 X No 10f. Zip Code 10g. Citizen of What Country? Funeral 7210 Indian Summer Lane 21702 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes Give Completed 3 Divorced 4 Divorced Specify White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ L. Lewren Sibert Anna Ruth Grove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Dunbar Ashbury, Jr/Husband 7210 Indian Summer Lane, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Mt. Olivet Cemetery XBurial 2 Cremation 3 Removal from State 5/12/2012 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 ove , or complications transcaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. art 1. Enter the disease, or complication mock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Respinatory tailu disease or condition resulting in death) Due to kir as a consequent of) ance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (r as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last S_{A} ndrome Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death in the past 12 month Ectopic pregnancy Month Day Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X** No ပ္ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate:

executed and -tran ng physician ar as the burial-t requires that the death certificate be Division of Vital Records, P.O. Box 68760 nse for ned by Hospital or Attending Physician: The law this certificate has page funeral director, After 24 hours after death. Funeral Director: A

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permit. Page 1 Department of Important: If it any injury or o

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Medical

Examiner

within 72 hours after

Baltimore, Maryland 21215-0036

27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined

1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 **Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

-2012

Ih. D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PANDEY Frederick 31. Date filed (Month, Day 32. Regir trar's Signature

State Registrar

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Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ 09 Amanda Jane Aulick Mau 2012 7:10 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5 White Oak Vista Court Silver Spring Montgomeru 5. Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 162-62-1554 1 □ M 2 🕱 F 46 09/07/1965 Minnesota 28a-f show 10a, State 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? items 23a Funeral 5 White Oak Vista Court 20904 u.s.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1995

If Yes, Give "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced White 1999 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Peter Kent Aulick Lois Ann McKeag 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Myron Garrison - Spouse 5 White Oak Vista Ct., Silver Spring, Maryland 20904 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Bloomington Grove Cem 05/19/2012 | Cogan Station, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death
2 Years Physician/ Metastatic Breast Cancer disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital Other: 2 X No 1 Tyes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 10+1 D35996 May 09, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda M. Burrell, 2730 University Blvd., West, #400, Wheaton, Maryland 20902 M.D.,

Registrar

31. Date filed (Month, Day, Year)

MAY 14 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2812 11.15 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 11354 Evans Trail, #204 Beltsville P.G. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Min (Month, Day, Year) Country Director 097-52-9414 1 □ M 2 🗓 F 41 Yrs 3, 1971 Usual Residence of Decedent Feb. NY 28a-f show item 27 is marked other than "naturel", or items 23a or 28a-f sho other treumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No MD P.G. Beltsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11354 Evans Trail #204 20705 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? Black, White, etc. Þ 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: Black 3 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 i h and Mental Hygiene. 7 is marked other than "r (Give kind of work done of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Administrator Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 end 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other treumatic e Hugh Mulzac Christobel Andrews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jameel Delpeche/Son 11354 Evans Trail, #204, Beltsville, MD 20705 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State May 14 Metropolitan Crematory 4 Donation 5 Other (Specify) 2012 Alexandria, VA 21. Signature of Funeral Service Licensee Francis Address Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician Breast Cancer disease or condition yrs Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injuly that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physicien: The lew requires that the death certificate be executed ettending physician end resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🖾 No Pregnant at time of death 5 Other (specify) Day ed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by After this certificate has been signed funeral director, page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: After this certification of the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1X Natural ☐ Accident Investigation 1 Yes 2 No 6 Could not be ☐ Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) MAY 15 2012

Harvinder Singh, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

203 Hospital Drive, #312, Glen Burnie, MD 1061 Registrar's Signa

29c. License numbe

12-03638 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 perstate of Maryland Department of Health and Mental Hygiene Latosha A. Allen 2012 16932 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ **Medical Examiner** Latosha Lynnette Allen May 11, 2012 2346 hrs Latosha A. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Months Days Hours Director 213-17-9330 2 X F Country) 1 M 37 Yrs Sept. 13, 1974 DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 X Yes 2 No more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland norn of Health and Mental Hygiene. Maryland Prince George's Clinton Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 12507 Windbrook Drive 20735 United States Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X Married 1 Never Married 2 X No Yes African If Yes, Give Year 1 Yes 2 No specify: 3 Widowed 4 Divorced Specify: 9 American 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self-Employed 12th Hair Stylist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leroy Larkins Sr. Linda Johnson ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leroy Larkins Sr. / Father 6928 Forest Terrace 20785 Landover, Maryland ot of Health a st. If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State timore, crematory or other place)
Washington 1 Burial 2 Cremation 3 Removal from State May 18, Department of Important: 4 Donation 5 Other Specify 2012 Suitland, Maryland <u>National Cemetery</u> 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Funeral Service License m M00560 20019 4001 Benning Road NE Washington, DC **Physician** Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Multiple Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760,
The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 ✔ Unknown icate has been sign page 2 should be d Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed: death? certificate ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be Other Nursing Home 5 Residence 6 Other this 1 Yes ۵ 27. Manner of Death 28a. Date of Injury 28b. Time of Injury After 28c. Injury at Work? 28d. Describe how injury occurred Certification: May 11, 2012 Subject pedestrian struck by motor vehicle Natural 2300 hrs Division death. 5 Pending 1 Yes 2 ✔ No the 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City within 24 hours after To the Funeral Dire 3 Suicide filled in 6 Could not be or Town, State) 12411 Windbrook Drive , Clinton , MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 12, 2012 OCME 30. Name and address of person who completed caute of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 242 A M Physician/ Barbara Jean Ruffin Anderson May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Community Hospital Prince George's Lanham Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex Days Hours Director 237-90-0986 1 X M 2 🗆 F Dec 18 1951 NC show 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified Prince George or 28a-f Lanham 1

X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7919 Johnson Ave 20706 U.S.A. iral", or items? Examiner mus Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. o. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 X No Specify: 3 ₺ Widowed 4 □ Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Certified Medical Tech PVT 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Katherine Williams Ruffin Columbus Hardy permit. Page 1 and 2 should Department of Health and M Important; If item 27 is mar any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alicia Ruffin 7919 Johnson Ave Lanham Md 20706 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Cheltenham Vet 2012 4 Donation 5 Other (Specify) Cheltenham Md 21. Sign thre of horral Service Lice cc02/57 22. Name and Address of Facility McLaughlin Funeral Home de 2518 PA Ave SE Washington DC 20020 23a. Part 1. Offer the disease, or complications that cave d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner burial-transi Cause (Disease of Injury that initiated events Due to (or as a consequence of): resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown mellitus . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes within 24 hours after death.

To the Funeral Director; After this certifics completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 2 Accident 5 Pending Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 06-2011 Walli

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Signature and title of certifier

29d. Date signed (Month, Day, Year)

ahham,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Alexander 2012 imothu Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death baltimore Samo 25014a If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Director 217-92-7163 1**X** M 2 □ F 47 09/06/1964 Wash., Usual Residence of Decedent 28e-f show 27 is marked other then "neturel", or items 23a or 28e-f sho treumetic event, the Madigal Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 X Yes 2 No Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15783 Haynes Road 20707 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify: Black 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 end 2 should be filed within 72 f Health end Mental Hygiene. Item 27 is marked other then Elementary/Secondary (0-12) College (1-4 or 5+) Professional CDL Driver US Postal æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, ပ Calvin M. Alexander Marion Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20707 <u>Donna L. Burnette-Alexander</u> 15783 Haynes Rd. Laurel, other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place permit. Pege 1 &
Depertment of F
Important: If Ite
eny injury or ott 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crem. 05/22/12 |Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Philip D. Rinaldi F. S Signature of Funera S rvice Licensee 9241 Columbia Blvd Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) neumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ettending physicien end for use as the buriai-transit that the deeth certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Vear signed by the e 1 Yes 2 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, cete has been sig ; pege 2 shouid b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificete 1 ☐ Yes 2 ☐ No Yes 2 ☐ No 124 hours after death.

9 Funerel Director: After this certific lietely filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospitel or Attending 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May 12, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. 1800 Orleans St. Balk More 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND12 Per FH State of Maryland / Department of Health and Mental Hygiene State Registrar 5/11/2012 AACO HEALTH DEPT. CMH Certificate of Death Decedent's Name (First, Midale, Last) 2. Date of Death 3. Time of Death Month 5/10/2012 Physician/ 6:40 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HERITAGE HARBOUR HEALTH CENTER ANNE ARUNDEL ANNAPOLIS 7. Age (In yrs. last birthday) Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 216-30-4507 1 **X**M 2 □ F 83 2/19/1929 MARYLAND Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl e notified 1 Yes 2 No MARYLAND ANNE ARUNDEL CROWNSVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? pe "natural", or items 23a Funeral 72 hours after death with 1326 ST. STEPHENS CHURCH ROAD 21032 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. þ 1 Never Married 2 X Married 1952 Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Single And Mental Hygiene.
27 is marked other than "natural" Completed Year or Dates. 1950 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 5+ CIVIL ENGINEER ENGINEERING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ GEORGE M. BALDWIN MARGARET JAEGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai once, KATHY MUSSELMAN/DAUGHTER 1326 ST. STEPHEN CHURCH ROAD CROWNSVILLE, MD 21032 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date DAVIDSONVILLE UNITED METHODIST CHURCH Burial 2 □ Cremation 3 □ Removal from State 5/12/2012 DAVIDSONVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) TES Signature of Funeral Service ELFENBEIN ENEWNAM CREMATION & FUNERAL CARE B14 BESTGATE ROAD ANNAPOLIS, MD 21401 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Mac disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the ! as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by trice 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? page perform Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work's 1 🗀 Yes 2 No after death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral I Medical Cept. (ing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Manie Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Ment | Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Co. The signed (Month, One). (Check within 2 To the 29b. Signature and title of ho completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Dav Year Month Physician/ 201 rolya, B Butler Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Musiland Medical lawer Bity of 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 24 Hrs 8 Date of Birth **Funeral** Months 1 □ M 2 **X** F 218-34-7695 Director 10/18/1936 MARYLAND 75 Usual Residence of Decede 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Director or 28a-f sl notified 1 ☐ Yes 2X No CHESTERTOWN KENT MD 10g. Citizen of What Country? 10f. Zip Code 10 10e. Street and Number must be Funeral "natural", or items 23a UNITED STATES 21620 24665 CHESTERTOWN ROAD death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Examiner Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married þ within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: WHITE If Yes, Give Year or Dates Completed 3 Widowed 4 XDivorced Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) FOOD SERVICE CASHIER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ANNA JACKSON JOHN HAROLD BROWN, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24301 CHESTERTOWN ROAD CHESTERTOWN, MARYLAND 21620 CHERYL BUTLER / DAUGHTER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 05/17/2012 HARRINGTON, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) HOLLYWOOD CEMETERY FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 Signature of Funeral Service Licenses Kuils Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ 500913 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner stage renal discoso Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine the burial-transit The law requires that the death certificate be executed discos oronary aftery and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Other (specify) Pregnant at time of death been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes Luous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy after death.

Director: After this certificate has d in by the funeral director, page 2.3 performed 1 Ves 2 No Yes 2 26. Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 🂢 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury 5 Pending Investigation 1 Natural 2 Accident
3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature)and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Grane

32. Registra s Signature

1760617872

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY" 10,28 2 MADELINE **ELIZABETH** BOONE 8:55A M Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 212-38-7574 Hours Min **Director** 1 □ M 2 □ XF 101 Oct. 8, 1910 Maryland Usual Residence of Decedent sho 10a. State items 23a or 28a-r sno ner must be notified at 10c. City, Town or Location the Maryland 10d. Inside City Limits Director MD Frederick Frederick 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5022 Old National Pike 21701 United States permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) School Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nellie Amanda Johnson Clyde Leatherman Harshman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 6922 Potomac Avenue, Braddock Heights, Maryland 21714 (Daughter) Connie Strasberger 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State zion Lutheran Church Cem. 1 XBurial 2 Cremation 3 Removal from State 5/14/2012 Middletown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basiord P.A. Funeral Home 106 E. Church Street, Frederick, M 21. Signature of Funeral Service Licenses Frederick, MD 21701 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) a consequence of: **Examiner** Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events burial-t Due to for as a consequence of resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No for Month Dav Year Pregnant at time of death should be detached g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) of person who completed cruse of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 06-2011

on

31. Date filed (Month, Day, Year)

400 West Seventh St., Frederick, MD 21701

State

31. Date filed (Month

MEYER, MD PhD

32. Registrar's Signature

Practicana

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ SHIRLEY ANN BURDETTE MAY 012 30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK GOLDEN LIVING CENTER FREDERICK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days 08/18/ 1 □ M 2 🖫 Yrs. MD Director 217-32-2882 76 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State Examiner must be notified at Director 1 Yes 2 No BOYDS MONTGOMERY MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ō Funeral items 23a 17000 DARNESTOWN ROAD 20841 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No ō þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE "natural", 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates. traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) within 72 permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) COUNTY SCHOOLS PUBLIC SCHOOL AIDE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HELEN IVY PARKS CLINTON FRANKLIN CARTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MAYNARD BURDETTE JR/SON KOHLHOSS RD. 17681 POOLESVILLE, MD 20837 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MONOCACY CEMETERY 05/10/201 1 Burial 2 Cremation 3 Removal from State BEALLSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ disease or condition ATHEROSCLEROSIS CORONARY ARTERY DISEASE Medical resulting in death) Examiner DEMENTIA Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed
24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and Exam attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 menths?
1 Yes 2 No Day Month Year Pregnant at time of death signed by the a Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Records, Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy funeral director, page 2 performed 1 🗌 Yes 2 🗌 No Yes 2 No 25. Was case referred to medical Division of Vital 26. Place of Dea h (Check only one) Be examiner? Hospital: Other: 2 No 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 Yes 2 🗌 No Investigation 2 Accident
3 Suicide
4 Homicide Accident the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completed (Check

State

To the I within 2

3 🗔

Α

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

KAZMI

only one

SIBTE

29b. Signature and title of

Registrar DHMH 17 Rev 7/2009 814 TOLL HOUSE AVE.,

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

FREDERICK

D47951

29d. Date signed (Month, Day, Year)

MAY 7, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 2012^{ear} May 13 9:05 Pm Stanley Moger Berry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington County 11314 Eastwood Dr. If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea 579-12-5884 88 1 XM 2 □ F Director Virginia Oct. 11,1923 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State notified at Director 1 ☐ Yes 2 🔀 No 28a-f Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 21742 U.S.A. 11314 Eastwood Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No If Yes, Give 1943 – Year or Dates. the Medical Examiner Black, White, etc þ 1 Never Married 2 X Married and 2 should be filed within 72 hours after theath and Mental Hygiene. em 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 🗌 Widowed 4 🗋 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
77 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Telephone Company Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edith Weeks Edwin Barton Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18205 Candlewood Lane Hagerstown, MD 21740 Timothy Berry-son Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State Smithsburg Crematory 5-15-2012 Smithsburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Lige 1331 Eastern Blvd. MD 21742 North Hagerstown, 23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on sa sed the death. Do not anter the mode of Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last and the burial-trai attending physician I for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has I this certificate 2 No 1 Yes filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 1 No Medical Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending 1 Natural work? 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Hemicide determined ertifi 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Che 3 nly ne) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete cause of death (Item 23a) (Type, Print 711-5+1

Registrar

State

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 May Month Physician/ Bellafiore 12. 5:45 Giuseppa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery National Lutheran Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Davs Hours Director 220-46-6954 1 M 2 X F 90 Sept. 17, 1921 Italy Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Montgomery Potomac 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 20854 USA 10501 Tanager Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 2 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, <u>the Me</u> Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Rosa Bellafiore Salvatore Mauro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10501 Tanager Lane, Potomac, MD 20854 Rosa Lombardo/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State $\frac{\text{May } 17}{2012}$ Gate of Heaven Cemetery Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Francis Address Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ANDREXIB Sequentially list conditions, if any, leading to immediate rame Friter Linderlying Cause (Disease or injury Due to (or as a consequence of): ending physiclan and r use as the buria transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 20051158 MAY 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE Mn 20850 VEIRS 9701 moth wy

State

Registrar

31. Date filed (Month, Day, Year)

MAY 15

3. Registrar's Sign

DHMH 17 Rev 06-2011

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		•	State Registrar			Cer	tificate of	Death			Reg. No. 2	012	16943
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~e			Washington Adv				Takoma					omery	
	Funeral Director		5. Social Security Number 577-18-2705	6. Sex 1 ☐ M 2 🏝 F	7. Age (In yrs. las		If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birl (Month, Da		9. Birthp Coun	olace (State or Foreign try)
			Usual Residence of Decedent	1 L M 2 12 F		Yrs.				5 25	1920	New Y	ork, NY
	shov d at	to	10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits
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ary	nd Me		19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street				er, City or Town	State, Zip (Code)
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<u>=</u>	Page ment ant: I		4 Donation 5 Other (S				ke Crema		5-18	-2012	Beltsv	ille,	Maryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21 Ignatur of Funeral Service	liceniee We	M0159		Name and Addr 005 12th						
			23a. Part 1. Enter the disease, of shock, or heart failure. List of	complications that	t caused the death	. Do not ente	er the mode of dyi	ng, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
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فمميد	Medical Examiner		resulting in death)	Due to	o (or as a con equi	ence of):	0	1.1		_			
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Box 68760	The law requires that the death certificate be execut rate has been signed by the attending physician and page 2 should be detached for use as the burial-transmission.	Completed by Physician/Medic	23b. Was decedent pregnant in the past 12 months?		utcome of pregnar		Ectopic pregnar	ncy				Date of deliv	
Bo	deatl he att	/sici	1 Yes 2 No	4 ☐ Pre 9 ☐ Un	egnant at time of de known	eath 5	Other (specify)					Month	Day Year
P.O.	at the d by t detack	Phy	Part II. Other significant condition	ons contributing to	death but not resu	ulting in the u	ınderlying cause g	iven in Part		23e. Did t	obacco use co	ntributè to tl	he cause of death?
o,	res th signe d be o	d by	Demus	ba.	noto	ali	Spri	llat	1027	1 🗆	Yes 2 □ No	3 🗆 Pro	bably 4 Unknown
ğ	requi been shoul	lete	Achar	1	00-11					24a. Was	an 24	o. Were auto	psy findings available
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<u> </u>	ificate or, pa		25. Was case referred to medical	<u> </u>			26. I	Place of Dea	ath (Check		2 S No	1 Yes	2 L3 No
Vita	ysicia s cert direct	To Be	examiner?	Hospital:	Inpatient 2 1	ER/Outpatie	nt 3 🗆 DOA Ot	her: 4 \square N	lursing Hor	ne 5 🗋 Resi	dence 6 \square C	ther (Specify	()
o	ng Ph ter th meral		27. Mann f Death 1 Natural 5 ☐ Pendir		te of injury onth, Day, Year)	28b. Time o injury	f 28c. Inju		2	8d. Describe I	how injury occ	urred	
on	eath. or; Af the fu	ifica	2 Accident Investi	igation			M 1 [Yes 2					
Division of Vital Records,	tal or Att rs after d al Direct ed in by	Il Certificate:								I Route Number,			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2 Medical E	g Physician: To the Examiner: On the b g Nurse Practition	asis of examination	and/or inves	tigation, in my opir	nion, death o	occurred at	the time, date a	and place, and	due to the ca	use(s) and manner state
	To the with Com		29b. Signature and title of certifier	n/06	Pusa	fu	29c. Licen	se number f St	71		29d. Date sig	ned (Month,	Day, Year)
	R		30. Name and address of person	who completed ca	use of death (Item	23a) (Type,	Print)			,	,	1	110
	41		Y chex,	s N=	19US	310	m-D	(UN	hing	tun,	HOV	. HOSPito
	Sta		31. Date filed (Month, Day Year)	32.	Registrar's Signat	ure				0.			,
	Registr		MAI TA CAIR	from 1	g. gar						·		
DHI	MH 17 Rev 06-	2011			-								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May Anna Mae Baney 2012 6:55pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Village Montgomery Victoria House 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month Day, 579-58-0091 Director 1 🗆 M 2 🗙 F 89 Yrs May Washington, DC permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone. 10c. City, Town or Location 10d. Inside City Limits Director Arlington 1 Yes 2 X No VA Arlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 22204 USA 5608 8th St. S. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 X Never Married 2 Married Black, White, etc. Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Research Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ethel Adams John Joseph Baney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10401 Grosvenor P1. #326 Rockville, MD 28052 19a. Informant's Name/Relationship (Type, Print) John F. McDonough/Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 5/14/12 4 ☐ Donation 5 ☐ Other (Specify) St. Mary Cemetery Alexandria, VA Signature of Funeral Service Lic 22. Name and Address of Facility Murphy FH 4510 Wilson Blvd. Arl., VA 22203 Une 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or her failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 1cavs Medical Examiner Due to (or as a consequence of) Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury Due to for as a consecuence of and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy☐ Pregnant at time of death 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has I page 2 autopsy perform death? Yes 2 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 PINO ျှ 4 ☐ Nursing Home 5 ☐ Residence 6 ★ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a

Registrar DHMH 17 Rev 06-2011 Me

OhN

MAY 1 4 2012

12-03600	
Jerry Baldwin	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

erry Baldwin	State of Maryland / Department 1-For State Certificate		/glene 2012 1694
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year May 10, 2012 3. Time of Death 1138 hrs
redical Examine	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
/	Prince George's General Hospital	Cheverly	Prince George's 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Funeral Director		If Under 1 Year If Under 24Hrs. Months Days Hours Min.	Dec 22 1935 Foreign Country) NC
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc		10d. Inside City Limits
≜ .π	DC Washingt	on	1 X Yes 2 No
death with the Maryland ritems 23a or 28a-f sho must be notified at once uner all Director	10e. Street and Number 4447 E. Street SE #14	10f. Zip Code 20019	10g. Citizen of What Country? U.S.A.
s 23 o c notifi		Was Decedent of Hispanic Origin? (Spr	
or items		f Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.
ال ال الوائد الوا	3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 No specify:	Specify: Black
2 hours "natu		lent's Usual Occupation (Give kind of w most of working life, DO NOT use retire	
5-0036 ed within 72 hour lygiene. other than "natt the Medical Exac	12th Ca	b Driver	Pvt
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. riced other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once Be Completed by Funeral Director	17. Father's Name (First, Middle, Last) Curtis Baldwin		(First, Middle, Maiden Surname) Iitchell Baldwin
2 등 등 및 O			ural Route Number, City or Town, State, Zip Code)
ore, MD 21 ges 1 and 2 should ges 1 and 2 should to Health and Me if If item 27 is man ther traumatic ov		Governor Heywa	-
of Hea	20a. Method of Disposition 20b. Place of Disposition 1 K Burial 2 Cremation 3 Removal from State Micchel	osition (Name of cemetery, other place) A Chanel May	Date 20c. Location - City or Town, State 2012 Pittsboro NC
Baltimore, permit. Pages 1 an Department of He Important: Utie injury or other tr	4 Donation 5 Other Specify:		
Ba perm Depa Impo	(1/1 mulling) 2	518 PA Ave,SE W	Laughlin Funeral Home ashington DC 20020
Physician Medical	23a. Part I. Enter the fire use, or complications that caused the death. Do not enter failure. List on! — he cause on each line.	r the mode of dying, such as cardiac or	respiratory arrest, shock, or heart Approximate Interval Between Onset and
Examiner	Immediate Caus. (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):		Death
	Sequentially list conditions, b		
iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause		* 1
ted Insit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	-	
and and	d. UNPENDED AMENDED	·	
	IF FEMALE: 23c. If yes, outcome of pregnancy	· · · · · · · · · · · · · · · · · · ·	23d. Date of delivery
Box 68760, e death certificate be the attending physicied for use as the burnhysicied for use as the burnhysician/Med	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnar Other (Specify)	Month Day Year
box 6876C the death certificate by the attending physiched for use as the brysician/Me	1 Yes 2 No 9 Unknown 9 Unknown	Other (Opecity)	
P.O. ss that the gened by the detacl	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✓ Unknown
Division of Vital Records, na or Attending Physician: The law requirers after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed			24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
Reco The law cate has page 2 si			performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
ital Recician: The scertificate Irector, page	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ▼ ER/Outpatie	26.Place of Death (Check of Death)	nly one)
1 of Vil	27. Manner of Death 28a. Date of Injury 28b. Time of	of Injury 28c. Injury at Work?	28d. Describe how injury occurred
Division (spital or Attending tours after death. neral Director: Af filled in by the fun Certification	1 Natural 5 Pending May 10, 2012 May 10, 2012 Natural 1042 hrs	1 ✓ Yes 2 No	Subject driver of vehicle
Divis pital or At ours after d teral Direct filled in by Certifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, si		28f. Location (Street and Number or Rural Route Number, City or Town, State) .archmont Avenue & Marlboro Pike, Capitol Heights, MD
Iospita 4 hours Nuncral	29a. Certifier A Contract Physician To the heat of my knowledge, death on		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigant manner stated.		the time, date and place, and due to the cause(s)
10 ×	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
12	Theofere M. Kit Thym.	O.C.M.E.	May 11, 2012
FL	30, Maffie and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner	900 W. Baltimore Street, Ba	ıltimore, MD 21223
State	31. Date filed (Month, Day, Year) 32. Registrar's Signatus		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Shelton Brooks Medical 05 2012 Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Apex Health of Silver Spring Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 07/24/1931 **Funeral** 9. Birthplace (State or Foreign Director 242-42-8930 1 № M 2 🗆 F 80 UNK ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery 1 X Yes 2 No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2700 Barker Street 20910 USA filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ð 1 Never Married 2 Married Black, White, etc. 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: Black Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 0 None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental P ဂ္ Page 1 and 2 should be UNK 19a. Informant's Name/Relationship (Type, Print) Nsq Home 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Amilia Apollon (Administrator) 2700 Barker Street, Silver Spring, MD 20910 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ö 1 XBurial 2 Cremation 3 Removal from State Department or Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel Cemetery :5/17/2012 Baltimore, MD Signature of Funeral Service 22. Name and Address of Facility Phillip A. Weatherford F.S. 2431 E. Oliver Street, Baltimore MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition resulting in death) dementia unknown Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injuly that initiated events resulting in death) Last Due to (or as a consequence of): Examir attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year ed by the a 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t d be det 23e. Did tobacco use contribute to the cause of death? þ dysphagia, Cerebovascular acciden Completed been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform I ☐ Yes 2 ☐ No 2 🗆 No **Division of Vital** director To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral To the Hospital or Attending Ph within 24 hours after death, To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation М 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Christy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W Laurel. CHOWDHURY, MD; 605 Main

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 10:58 DM Ra Sa lay Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death inversity of Maryland Medical Cent social Security Number 16. Sex 7. Age (In yrs. last birthday) Baltimore MD Baltimore If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min 578-56-3327 68 Director 1 □ M 2 🖾 F May 22, 1943 Raleigh, NC 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified MD Prince George's Forestville 1
¥ Yes 2 □ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2611 Luana Drive, Apt 104 20747 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 K No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. **Black** Specify: "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.

It is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Private 4 Years Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pearlie Mae Mack Nathan Floyd Cannady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 20011 Ivy Bean - Daughter 1352 Rittenhouse St., NW, Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date 1 ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State cemetery, crematory or other place, 05/15/2012 Chesapeake Crematory Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home ervice Licen 21. Signi f Fune 716 Kennedy Street, NW, Washington, DC Part 1. Enter the disease, or come shock, or heart failure. List only or he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final enterococcus Cacterenia Physician/ disease or condition Medical resulting in death) **Examiner** resistent Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events and hypotension burial-tran resulting in death) Last physician Physician/Medical ailu Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE; 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ jo in the past 12 months? Month Day Year ☐ Pregnant at time of death
☐ Unknown signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ anoxia 1 Yes 2 No 3 Probably 4 Unknown Completed Chronic respiratory 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 rengi - Stage 2 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 🗌 Yes 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 3

W

State Registrar who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2012 02:45PM May William Nelson Brown Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Ceci1 78 White Birch Drive North East 9. Birthplace (State or Foreign Country) Salem New Jersey 8. Date of Birth If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Month, Day, Year) Dec. 21, 1925 1 XM 2 □ F Hours 86 New **Director** 157-18-6326 Usual Residence of Decedent show 10d Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland at Director or 28a-f sh notified a 1 Yes 2XXNo Maryland Ceci1 North East 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral United States 21901 78 White Birch Drive hours after death 12. Was Decedent Ever in U.S.
Armed Forces? Army
1 Xyes 2 NAIR
If Yes, Give
Year or Dates.1944-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. þ 1 Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 - Widowed 4 - Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) Electric Company Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Carroll Stratton Brown Estelle M. Nelson traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21901 78 White Birch Drive, North East, Maryland Margaret R. Brown / Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition 2 X Cremation 3 Removal from State on 5 Other (Specify) Mayerdale Crematory | May 10,2012 | Newark, Delaware 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland 21901 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit Exami death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 9 Unknown To the Hospital or Attending Physician: The law requires that the c within 24 hours after death. To the Funeral Director: After this certificate has been signed by th g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6+1 VA

38 State

29a. Certifier (Check

only one)

29b. Signature and title

ELKHUN 32. Registrar's Signature

GOPEZ MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

65902

29d. Date signed (Month, Day, Year)

10/12

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Goldie C. Bass 2 2012 14:50 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 X F Director 578-12-0363 95 March 6 1917 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Rockville 1 X Yes 2 □ No be notified MD Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ö 20852 United States items 23a 6121 Montrose Road, #506 Examiner must Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Nidowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Beauty Salon Receptionist Department of Health and Mental Hygin Important: If Item 27 is marked other any injury or other traumatic event, if once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dulberg Ceppos Pearl Jacob 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16201 Oak Meadow Drive, Rockville, MD 20855 Frederick A. Bass / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crem. 5/4/2012 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home Xoy P. O. Box 5038, Laytonsville, Maryland 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Non-Traumatic Subarachnoid Hemorrhage /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to finite late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a ponsequence off Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician ar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Cardiomyopathy 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 M No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation Injury 1 X Naturai M 1 ☐ Yes 2 ☐ No il Director: / 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar DHMH 17 Rev 1/2001

Medical

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Yaneng Oswald Li, M.D.

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

8600 Old Georgetown Rd., Bethesda, MD

D 67986

29d. Date signed (Month, Day, Year)

May 2, 2012

20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 23A, PER MD G930, 8/16/12 TRT, State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ A. Bedard ZOIZ 8=44AM Laura max Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Doctor's Community Hospital Prince George's Greenbelt Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral Hours (Month, Day, Year) 212-52-6056 Director 1 M 2 X F 55 Jan. 27 1957 Delaware Usual Residence of Deceden 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified College Park 1 Yes 2 X No Prince George's MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20740 5718 Berwyn Road United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ö þ 1 X Never Married 2 Married Specify: White 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 - Widowed 4 - Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) State University Law Librarian and Mental Hygier is marked other t zedara, Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Donald Bedard Lydia Armbruster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heidi Leinneweber / Sister 24930 Dunnavant Drive, Gaithersburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗌 Burial 2 🗷 Cremation 3 🗍 Removal from State cemetery, crematory or other place) Alexandria, Virginia 5/8/2012 Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Muriel H. Barber Funeral Home Laytonsville, Maryland 20882 W, XQY P. O. Box 5038, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner LOWER GASTROINTESTINAL BLEED Sequentially list conditions, Examine Due to for as a consequence of n any, leading to immediate cause. Enter Underlying death certificate be executed Cause (Disease or injury that initiated events ACUTE RESPIRATORY FAILURE Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 ☐ Yes ∠ ☐ Unknown the P.O. signed by 1 d be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Jas performed? Yes 2 1 Yes 2 No 25. Was case referred to medica **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: within 24 hours after death.

To the Funeral Director: After t completely filled in by the funer. 1 Natural To the Hospital or Attending Accident 5 Pending 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 05-07-2012 20102 of person who completed cause of death (Item 23a) (Type, Print) 8118 Good Lucked, Carham, MD. 20706 40 Zama, mDo, 32. Registrar's Signature State Registrar

23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Arturo Α. Betancourt May [□]2012 8, 9:30 Рм Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens at Riderwood Village Silver Spring P.G. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 581-88-6474 Director 1 🛛 M 2 🗆 F Dec. 4, 1925 Cuba Usual Residence of Deceden shov 10a. State at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f P.G. MD Silver Spring 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code r items 23a or ner must be r 10g. Citizen of What Country? Funeral 3160 Gracefield Road 20904 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Cuban White If Yes, Give Year or Dates 1
Yes 2
No Specify: "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Lawyer Legal event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည Department of Health and Men Important: If item 27 is marke any injury or other traumatic Arturo E. Betancourt Ana Morales 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arturo E. Betancourt/Son |14721 Silverstone Drive, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State cemetery, crematory or other place May 2012 Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA Signature Funeral Service Lig 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W, Silver Spring Mu MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician a Alzheimer's Disease disease or condition 10 yrs Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trar and Due to (or as a consequence of): attending physician Be Completed by Physician/Medical signed by the cause of death? ably 4 🗌 Unknown sy findings available pletion of cause of page 2 s ☐ No ၉

requires that the death certificate be Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician; The law within 24 hours after death.

To the Funeral Director: After this certificate has b.

the Maryland

with

and 2 should be filed within 72 hours after death

Page 1

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Ye			
Part II. Other significant conditions Asthma, Hyperter	contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of dea			
Ascima, hypercer	151011	1 Yes 2	No 3 Probably 4 U			
		24a. Was an autopsy performed?	24b. Were autopsy findings av prior to completion of cal death? 1 Yes 2 No			
25. Was case referred to medical examiner?	26. Place of Death (Check	only one)				
1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon	ne 5 🗆 Residence 6	3 ☐ Other (Specify)			
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could not	on (Wonth, Day, Year) Injury work? M 1 \(\sum \) Yes 2 \(\sum \) No	28d. Describe how injury occurred				
3 Suicide 6 Could not 4 Homicide determine		28f. Location (Street and Number or Rural Route Number City or Town, State)				

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed

(Month, Day, Year) 912

29c. License numbe

State Registrar

pletely filled in by the

Certificate:

Medical

29a. Certifie

(Check

only one)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eileen Gemmell, CRNP 3110 Gracefield Road, Silver Spring, MD 20904

31. Date filed (Month, Day, Year, 32. Registrar's Signature MAY 1 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	- State Amend #1,	State of Ma 5/21/201	aryland	d / Depa er /Dr	rtment of F	lealth and N eat a1		giene Reg. No. 2	012	16953
			Registrar 1. Decedent's Name (First, Middle,		- , <u>r</u>	067	inigato of E		2. Date of De	ath	<u> </u>	3. Time of Death
	Physicia	1/				Ann Burk	Month May			4:43 рм		
W.	Medic Examin		4a. Facility Name (if not institution, give street and number)				4b. City, Town, or	Location of Death			ty of Death	
man pi			Laurel Regiona				Laure				ce Geo	
	Funeral	5	Social Security Number 227-64-3120		e (In yrs. Ia 53	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th <i>y</i> , <i>Year)</i>	9. Birth	**
	Director		Usual Residence of Decedent	1 □ M 2 🔀 F	55	Yrs.			04/17/1	.959		PA
	and show	ē	10a. State 10b. County		10c. City	, Town or Loc	eation					10d. Inside City Limits
	Maryl 28a-f otifie	Director	MD Hor	ward		Laure						1 🗌 Yes 2 🔀 No
	h the	aD	Oe. Street and Number				10f. Zip Code	•	-	10g. Citizen o		
	ith wit ms 2; must	Funeral	10525 Bill L	12. Was Decedent 6	ver in U.S	13. V	2072.	ispanic Origin? (Sp	ecify Yes or No-		ted St	
' O	or ite	by Fi	11. Marital Status1 ☐ Never Married 2 XMarri	Armed Forces?		l1	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		ack, White,	
036	rsafte ural", Exar	ed	3 🗌 Widowed 4 🗌 Divorced	If Yes, Give Year or Dates.		1	Yes 2x No	Specify:		Speci	fy:	White
21215-0036	2 hou "natu edica	Completed	15. Deceden (Specify only highes	t's Education t grade completed)		(Give I	lent's Usual Occup kind of work done	ation during most of worl	king	16b. Kind of	Business/I	ndustry
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d 2	led wi Hygik other ent, t	on t	17. Father's Name (First, Middle, La			Denie	I PRINCE	18. Mother's Nan		Maiden Surna	me)	
/lan	d be fi Aental Irked Itic ev	입	Paul Robson S	ailer				Joan I	Elizabet	h Pace		
Maryland	should and N is ma	- [19a. Informant's Name/Relationsh					and Number or Ru				
<u>ک</u>	and 2 Health	-	Dennis G. Burke	e - Husband	20h F		Sition (Name of	ily Court	Date	20c. Locatio	2072	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		1 Burial 2 Cremation		C	emetery, cren	natory or other plac	i	L7/2012		Gardei	- 1
ij	nit. Pa artme ortan injuny	ŀ	4 ☐ Donation 5 ☐ Other (S		Ne		Hill Cem . Name and Addre					ily FH Inc.
Ba	Depar Impor any in	ı	& morel	mato								, MD 21043
			23a. Part 1. Enter the disease, of shock, or heart failure. List o	complications that cause	d the deat	h. Do not ente	er the mode of dyir	ig, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
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-	Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):					}	
		er	Sequentially list conditions,	b. Due to (or as			ung Met	dStasis				
	ted L Insit	Examiner	of any, reading to immediate cause. Enter Underlying Cause (Disease or injury				Arrest					
	certificate be executed anding physicial and and use as the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):						
09	re be nysicia	dical		d		··	<u> </u>				- 17	
_	rtifica ing ph e as t		IF FEMALE:	23c. If yes, outcome	of preams	ancy				224	Date of del	ivon
Box 687	death certifica ne attending pl ed for use as t	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No	1 Live Birth	2 - Feta	aldeath 3 L	Ctopic pregnan Other (specify)	cy		- 1	Month	Day Year
	\$ 9 B	nysi	9 Unknown	g 🗌 Unknown								
P.0	The law requires that the death ate has been signed by the atterpage 2 should be detached for	by Physician/M	Part II. Other significant condition	ns contributing to death	out not res	sulting in the u	ınderlying cause g	iven in Part I.				the cause of death?
	quires en sig ould b	pel								_		robably 4½ Unknown
COL	aw rec as bee	Completed								s an 24 opsy formed?	b. Were au prior to death?	topsy findings available completion of cause of
Re	sician: The law r certificate has k lirector, page 2 s								1 \(\text{Yes}	2X No	1 Yes	s 2 🗆 No
tal	ician: certific	Be	25. Was case referred to medical examiner?	Hospital:			Ott	Place of Death (Che			Oth ex (0 = ==	
Į V	Attending Physician: If death. ector: After this certific by the funeral director,	2	1 Yes 2X No 27. Manner of Death	28a. Date of inj	ury	ER/Outpatie 28b. Time o	f 28c. Inju	ry at	dome 5 Res	how injury occ		aryy
ou c	nding ath. r: Afte ie fune	icat	1 Natural 5 Pendir 2 Accident Investi	gation	ay, Year)	injury	M 1 [k?]Yes 2☐ No				
Division of Vital Records,	r Atter er deg rector	Certificate:	3 Suicide 6 Could 4 Homicide determ		jury - At h	ome, farm, st	reet, factory, office			(Street and Number)	mber or Ru	ral Route Number,
Ö	ital or urs afte ral Dir			Physician: To the best of				and place	and due to the	cause/s) and m	anner as st	ated
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical	101 1 0 1 14-15-17	Examiner: On the basis of Nurse Practitioner: To t	evaminatio	and/or invo	tigation in my onin	ion death occurred	at the time, date	and blace, and	que to the	cause(s) and manner stated.
	To the within 2 To the comple	Σ	only one) 3 L Certifying 29b. Signature and title of certifier		ne best of	thy knowledge	29c. Licens			29d. Date sig		
	,- ,- 0)	Vary Ko	2			D1660	5	5	1111	112
	10		30. Name and address of person	who completed cause of	death (Iter	n 23a) (Type,	Print) Wang	Koon, MD	10 -	1/-	.0	MD 20707
	,		Laurel Per	Zional Hys	pidall	ature #	300 /	un Dus	con 1000	71. La	unce	, , , , ,
	Sta Registr		31. Date filed (Month Panyear) v	4 2012 32. 191st	rar s Signa	A.	barrel					h l

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year **JOSEPH** BRENNAN JR. **EDWARD** 12:53P Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3985 LEE LANE WHITE PLAINS CHARLES Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days 1 ★M 2 □ F Hours Min 035-26-9238 Yrs **Director** 70 .1942 RHODE ISLAND FEB.1 Usual Residence of Decedent 28a-f show 10b. County with the Maryland 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director MD 1 Yes 2XNo CHARLES WHITE PLAINS 10e, Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 3985 LEE LANE 20695 U. S. A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner musonce. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 N

If Yes, Give

Year or Dates. 6 Black, White, etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify 3 Widowed 4 Divorced Specify: WHITE Completed 91 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16a 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DIRECTOR OF TRANSPORTATION STATE DEPT. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ EDWARD J. BRENNAN SR. CATHERINE A. DAVIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL BRENNAN/SPOUSE 3985 LEE LANE WHITE PLAINS, MD 20695 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State emetery, crematory or other place ARLINGTON NAT.CEM 8-6-12 ARLINGTON, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service Licenses M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ance Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): use as the burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Unknown Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Yes မှု 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 2 Accident 5 Pending Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contifying Nurse Pranticipe: T. 11, 100 to 1 from control of the following state of the cause (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

State

0

9 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 18 Day 2012 Year Louise Morrison Boyer 2:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Glade Valley Nursing and Rehab Ctr Walkersville . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland Jan. 31, 1920 Days Hours Min. 217-30-7166 Usual Residence of Dece Director 1 M 2 XF 92 if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Frederick Jefferson 1 🗆 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5727 Broad Run Road 21755 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file.
Department of Health and Mental H
Important: If item 27 is marked ot
any Injury or other traumatic even Clyde Morrison Anna Stottlemyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rick Boyer / Son Catholic Church Road, Jefferson, MD 21755 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul's Cemetery May 22, 2012 Jefferson, Maryland 21. Signature of Funeral Service Licenses Keeney and Basford PA Funeral Home, 106 East Church Street, Frederick, 23a. Mrt 1. Enter the disease, decomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death >3 Years shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) C.V.A. (Multiple T.I.A's) , Medical Due to (or as a consequence of) Examiner 3 Years Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the attending physician and ched for use as the burial-transit Cause (Disease or injury Pulmonary Disease 2 Years that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Atrial Fibrillation >2 Years 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 A No
9 Unknown Day 5 Other (specify) Month Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of After this certificate has a funeral director, page 2 autopsy performed' 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HOX, CRNP May 18, 2012 R087864 10 de 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amy Fox, CRNP 6695 Stoneridge Court, Frederick, Maryland 21702

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Cortificate of Death

Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/ Medical Examiner

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and peoppleted filled in by the funeral director, page 2 should be detached for use as the burial-fransit Division of Vital Records P.O. Box 68760
To the Hospital of Attending Physician The law requires that the death certificate be seen

	1	1109.04.41	Certificate of Death	Reg. N	.2012	16957							
Physician. Medica		1. Decedent's Name (First, Middle, Last) Earlease Mosley Carry		2. Date of Death Month May 5, 201	ay Year	3. Time of Death 6:57a ^M							
Examine		4a. Facility Name (if not institution, give street and number) 5411 20th Avenue	4b. City, Town, or Location of Death Hyattsville		c. County of Death	Georges							
Funeral Director		5. Social Security Number $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	/rs Months Days Hours Min.	3. Date of Birth (Month, Day, Year) Jan 26, 1	Cou	hplace (State or Foreign intry) r ginia							
28a-f show otified at	- 1	Usual Residence of Decedent 10a. State	or Location H yattsville			10d. Inside City Limits 1✗✗Yes 2 □ No							
s 23a or nust be n	runeral <i>D</i>	10e. Street and Number 5411 20th Avenue	10f. Zip Code 20782		10g. Citizen of What Country? United States								
o amin	2	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black								
giene. er than "nati the Medica	Completed	(Specify only highest grade completed) Flementary/Seconday (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I ministrative Assistant		16b. Kind of Business Industry Church								
rked othe tic event,		17. Father's Name (First, Middle, Last) David Mosley	18. Mother's Name (F Mozell										
alth and N 27 is ma er trauma			Mailing Address (Street and Number or Rural R 5411 20th Avenue, Hy	Route Number, City o	or Town, State, Zip Marylan o	^{Code)} 1 20782							
ment of He tant: If item lury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 5/10/2012 20c. Location - City or Town, State Brentwood, Maryland											
Depart Import any inj once,		21. Signature of Funeral Service Licensee/	22. Name and Address of Facility MCG 7400 Georgia Avenue										
ysician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Failure to Thrive Due to (or as a consequence of): Dysmobility Due to (or as a consequence of): Due to (or as a consequence of):											
kaminer	. l												
and I-fransit	Evallille	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of	fi:										
as the burial-fransit	anical	End Stage Rhen	natid Arthritis	thritis									
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completed filled in by the funeral director, page 2 should be detached for use as Modical Contrification To Be Completed by Dhysician/Me	- 1	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 │ Yes ②XXNo g │ Unknown 23c. If yes, outcome of pregnancy 1 │ Live Birth 2 │ Fetal death 4 │ Pregnant at time of death g │ Unknown	3		23d. Date of deli Month	very Day Year							
an signed build be deta	3	Hypertension 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.											
cate has been si				24a. Was an autopsy performed?	prior to death?	opsy findings available ompletion of cause of 2 No							
nis certifi I director	١	25. Was case referred to medical examiner? 1 Yes 2XXNo	26. Place of Death (Check or	nly one) e 5 Residence	6 Other (Speci	6.0							
ath. r: After this le funeral c	- I	27. Manner of Death 28a. Date of injury 28b. Tir		d. Describe how inju									
s after death. In Director: After ad in by the funer	- 1	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office 28										
in 24 hours he Funeral poleted filled	Medica	29a. Certifler (Check only one) 1 **X**Certifying Physician: To the best of my knowledge, do only one) 2 **Medical Examiner: On the basis of examination and/or only one) 3 **Certifying Nurse Practioner: To the best of my knowledge, do	investigation, in my opinion, death occurred at the	e time, date and place	e, and due to the c	ause(s) and manner stated.							
To to		29b. Signature and title of Artifier	29c. License number D0051473 MD		ate signed (Month) Lay 8, 20								
		30. Name and address of person who completed cause of death (Item 23a) (Ty Kathy S. Brenneman, M.D. 1160 Va	ype, Print) irnum Street, NE, Wash	ington DC	20017								
State Registrar	- 10	31. Date filed (Month, Day, Year) 32. Registrar's Signature	pare										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jannie Champ 4:30a M 2012 Mau Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Arcola Nursing Home Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours Min (Month. Dav. Year) 577-52-5647 **Director** 1 □ M 2 🕱 F 75 April 16,1937 North Carolina Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City. Town or Location notified at Director 1 Yes 2 X No Montgomery Silver Spring Maryland 10e Street and Number 10f. Zip Code or items 23a or miner must be n ö 10g. Citizen of What Country? Funeral 20902 901 Arcola Avenue U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 X Divorced African-American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Unknown of Health and Mental Hygie item 27 is marked other other traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ...ylv.
...ge 1 and 2 should be ...
...opartment of Health and Mental Important if frem 27 is merany injury or other ... ပ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Davis - Guardian 401 Hungerford Drive, 2nd Floor, Rockville, MD 20850 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 05/14/2012 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute Funeral & Cremation Damell an Center. 1040 Rockville Pike, Rockville, MD 20852 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line. 23a. Part 1. Enter the shock, or heart fail Onset and Death Immediate Cause (Final Physician/ Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Diabetes Mellitus Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events s the burial-transit Hypertension The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Hupothuroidism as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ for in the past 12 months?
1 Yes 2 X No Day Year Month Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 X No page 2 To the Hospital or Attending Physician: The Within 24 hours after death. 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 💢 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify 1 ☐ Yes 2 X No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred work? 1 ☐ Yes 2 ☐ No X Natural 5 \square Pending Accident Investigation pletely filled in by the Suicide Could not be

State Registrar

DHMH 17 Rev 06-2011

Medical

vithin 24 hours

4 Homicide

3

Ghousid Sultana. 31. Date filed (Month, Day, Year)

29a. Certifier (Check

determined

X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D56691

12107 Heritage Park Circle, Silver Spring, Maryland 20906

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sign

M.D.,

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month. Day, Year)

May 07, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Helen Cowherd Medical May 8, 2012 0416 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. | Months | Davs | Hours | Min. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 225-32-8184 **Director** 1 □ M 2 🎛 F 100 April 19,191 Usual Residence of Decedent 28a-f show 10a. State 10b. County be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD PG Suitland 1 XYes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **23**a Funeral must | 6009 Elmendorf Drive 20746 United States within 72 hours after death 1. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian Armed Forces?

1 Yes 2 No o Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", If Yes, Give 1 Yes 2 No Specify. 3 X Widowed 4 Divorced Completed Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. the Unk. None None marked other traumatic event, Be 17. Father's Name (First, Middle, Last) ealth and Mental H 18. Mother's Name (First, Middle, Maiden Surname) ည John Payne Estella Mosby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
er Suitland, MD. 20746 Page 1 and 2 sment of Health <u>Barbara Perkins/granddaughter</u> item 2 other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of F Important: If ite any injury or otl 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Mem. Gardens 5/21/12 Waldorf, MD re of Funeral Service License 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause cleratic thero 5 Cardioussulm Immediate Cause (Final Physician. disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying
Cause injury Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year 1 ☐ Yes 2 ☐ Unknown ☐ Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available certificate has prior to completion of cause of death?

1 Yes 2 No autopsy performed? 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 24 hours after deaun.

• Funeral Director: After this c |은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manne Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 9 05 0 6

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink	. Ensure All Copies Are Legible
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eith Alan Clari	(State of Ma 1- For State Registrar	aryland / Depart <i>Certi</i> i	tment of ficate of		Mental Hy	_	g. No. 20	12 169
Physici ledical Exam		Decedent's Name (First, Middle,Last)	0.7 1				Date of Deat Month	h Dav Year	3. Time of Death
redical Exam	mer	Keith Alan Clark May 16, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death						1703 hrs	
		Civista Medical Center	La Plata Charles Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birth Months Days Hours Min. Foreign						
Funeral Director		5. Social Security Number 6. Sex 1 1 3 M 2							
any		Usual Residence of Decedent 10a, State 10b, County	10c. City. To	own or Location	n				10d, Inside City Limits
*	_	Maryland Charles	, , , , ,		aldorf			1 X Yes 2 No	
darylar 28a-f s	Director	10e. Street and Number		· T	10f. Zip Code	aldori	10	g. Citizen of What Co	Intry?
th the ? 23a or notifie		3085 Dorsey Court				602			States
eath wi	Funeral	1 Never Married 2 Married Ar	as Decedent Ever in U.S. ned Forces?		Decedent of Hispa s, specify Cuban, N			14. Race - Ame White, etc.	rican Indian, Black,
after d	by Fu	3 Widowed 4 Divorced If Yes, G	:	1 🗆 🗎	res 2 X No	specify:		Specify: B1	ack
hours "natur	ted	15. Decedent's Education (Specify only higher Elementary/Secondary (0-12) Col	st grade completed) 16 ege (1-4 or 5+)		Usual Occupation at of working life, D			16b. Kind of Business	(Industry
036 ithin 72 ne. r than	Completed	12th	090 (1-4 01 01)		Custod	ian		Gover	nment
filed will Hygie dother it the N		17. Father's Name (First, Middle, Last)				.Mother's Name (First, Middle, M		
MD 21215-0036 at 2 should be filed within 7 th and Mental Hygiene. a 27 is marked other than	o Be	Purcell Clark 19a. Informant's Name/Relationship (Type, Prin		19b. Mailing	Address (Street a	Emma I and Number or Ru	Deloris Iral Route Numi	Williams ber, City or Town, State	e, Zip Code)
MD d 2 sho lith and n 27 is		Tammy Burton / Sister	-In-Law	15107	Peartree	Drive	Bowie,	Maryland	20747
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Menal Hygienei. Then 27 is marked other than "natural?, or items 23a or 28a-f she or other traumatic evect, the Medical Examiner must be notified at socc.		20a. Method of Disposition 1 X Burial 2 Cremation 3 Rem		ce of Dispositi matory or othe	on (Name of ceme r place)	tery, May	Date 24,	20c. Location - City o	Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Her		Cemetery me and Address of		2012	Waldorf,	
Den Dem		John T. Stewart	M00560	40	01 Benni	ng Road	NE Wash	uneral Homington, DC	
Physician // // // // // // // // // // // // //		23a. Part I. Enter the disease, or complications failure. List only one cause on each line.		not enter the	mode of dying, su	ch as cardiac or r	espiratory arre	st, shock, or heart	Approximate Interval Between Onset and
Examiner			ertensive At	heroso	lerotic	Cardiova	scular	Disease	Death
4	_	Sequentially list conditions, b						·	
	mine	cause. Enter Underlying Cause (Disease or injury that initiated	or as a consequence of):						
cuted nd nd ransit	ledical Examiner	events resulting in death) Last Due to (c	or as a consequence of):						
Sox 68760, death certificate be executed te attending physician and for use as the burial - transi	dica		DED#9,23a,27,	_	,g928 6-	19-12 sn	n.		
Box 68760, c death certificate be the attending physic of for use as the bur			yes, outcome of pregnan- Live birth		death 3	Ectopic pregnanc	⊃y .	23d. Date of deliver Month	y Day Year
Box 6876 he death certificate the attending phy hed for use as the I	Physician/N	1 Vos 2 No 9 Unknown 4	Pregnant at time of death Unknown	- =	r (Specify)				
- o = 5			ting to death but not resul	ting in the und	derlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
s, P.O. uires that the signed by d be detach	ed by							2 No 3 Pro	pably 4 Unknown
of Vital Records, og Physiciae: The law requir ther this certificate has been s neral director, page 2 should I	Completed						24a. Was ar autops perforn	y prior to	utopsy findings available completion of cause of
ital Recordictors. The law is certificate has become		25. Was case referred to medical			26 Place of	Dooth (Charles	1 ✓ Yes 2		es 2 No
Vital ystclan his cert directo	o Be	examiner? 1 ✓ Yes 2 No	☐ Inpatient 2 ✓ ER	/Outpatient		Death (Check on		tesidence 6 Othe	r:
e# . ~4	ä	27. Manner of Death 28a.	Date of Injury 28i (Month, Day,Year)	b. Time of Inju		it Work? 2	8d. Describe ho	w injury occurred	
Division tal or Attendit rs after death.	icati	2 Accident Investigation 28e	Place of Injury - At home	. farm. street.			8f. Location (St	reet and Number or Ru	ural Route Number, City
Div	Certification:	Suicide Could not be	ecify)	, , , , , , , , , , , , , , , , , , , ,	,,		or Town, Sta		arred rambor, only
Division of Vital To the Hospital or Attending Physiciae: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physician: To the cone) 2 Medical Examiner: On the band man							
F S F S	×	29b. Signature and title of certifier	7/ 1/0	*	29c. License n			29d. Date signed (Mo	nth, Day, Year)
	-	30. Name and address of person who completed	cause of death (Itam 22-	<u>, , , , , , , , , , , , , , , , , , , </u>	O.C.M.I	E.		May 17, 2012	
			Medical Examiner		Baltimore Stre	et, Baltimore	, MD 21223	3	
St Regist	ate rar	31. Date filed (Month, Day, Year)	2. Registrar's Signature	1					
	_								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 May 6, 2324 James Henry Carter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fort Washington Prince George's Fort Washington Hospital If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, an. 14 1 ፟ M 2 □ Months Davs Hours Country) Tennessee 80 Director Jan. 578-40-4377 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10d. Inside City Limits nit, Page 1 and 2 should be filed within 72 hours after death with the Maryland rartment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shor injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 🖺 Yes 2 🗌 No Prince George's Oxon Hill Maryland 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 20745 United States 5628 Fargo Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🛣 No Specify. 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) General Services Elementary/Seconday (0-12) College (1-4 or 5+) Administration Assistant Chef 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Jackson William Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Gladys T. Carter - Wife 5628 Fargo Avenue Oxon Hill, Maryland 20745 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 16, permit, Page 1 a Department of H Important: If ite any injury or ot Maryland Veterans Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 Cheltenham, Maryland Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility tervai M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ischemic Heart Disease disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Deep Vein Thrombosis of Lower Extremity Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Hypertension Due to (or as a consequence of): resulting in death) Last Physician/Medical Type 2 Diabetes Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death
Unknown 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🖾 No 1 🗌 Yes မှ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After it completed filled in by the funera (Month, Day, Year) injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medica Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) May 14, 2012 D14760 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Stephen Org M.D.

Oxon Hill, Maryland

6357 Oxon Hill Road

32. Be

Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

		State Registrar	aryland / D	Certificate			and N	,	Reg. No.	20	12 1696	
Physician Medic		Decedent's Name (First, Middle, Last) Vung Tsung Chen						2. Date of De Month	ath Day	-/2°	3. Time of Death	
Examine	er	4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Cente	r	4b. City, 1	Town, or napo		of Death			County of Done	Death runde1	
uneral irector	5. Social Security Number 155-22-5770 6. Sex 1 \overline{\foating M} M 2 \overline{\text{F}} F 157. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/24/1922								g.	9. Birthplace (State or Foreign Country) China		
a-f show ified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince George s	10c. City, Town o	or Location				, ,			10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
23a or 28 ist be not	Funeral Dir	10e. Street and Number 4300 Regent Lane	DOWLE	10f. Zip	Code 0715				_	en of Wha		
il", or items xaminer mu	<u>ک</u>	11. Marital Status 1 Never Married 2 M Married 1 Never Married 2 M Married 1 Yes Give	No	13. Was Decede If Yes, speci	fy Cubar	n, Mexica	n, Puerto		1	4. Race - A	American Indian, White, etc. Asian	
ne. han "natura e Medical E	Completed	3 ☐ Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5	16a. D (0 5+)	Give kind of work fe. DO NOT use	dent's Usual Occupation kind of work done during most of working O NOT use retired)					16b. Kind of Business/Industry U. S. Department of		
	a l	17. Father's Name (First, Middle, Last) Lee Ting Chen	E1	ectronio	cs E		er's Name	e (First, Middle,		he Na umame)	avy	
ealth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) James L. Chen/Son		Mailing Address 04 West							, Zip Code) 20715	
ment of He ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery,	Disposition (Nam crematory or oth Cremator	her place		5/5/2	Date 2012			y or Town, State Maryland	
Departi Import any inj once.		21. Signature of Funeral Service Moensee 22. Name and Address of Facility Robert E. Evans Funeral Home, 16000 Annapolis Road, Bowie, Maryland 20715										
ysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Suumbury of the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death										
Medical xaminer	-e-	resulting in death) Duald (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):										
and I-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
physician s the buria	g	La. GE										
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 Ectopic pi 5 Other (spe		′			2	3d. Date of Month	f delivery Day Year	
en signed b	ا ۾	Part II. Other significant conditions contributing to death b	the underlying ca	ause give	en in Part	l.	23e. Did to			e to the cause of death? Probably 4 Unknown		
ate has be	Completed							24a. Was autop perfo 1 Yes		prior deat	e autopsy findings available to completion of cause of h? Yes 2 \square No	
certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:			Other	p)		only one)				
th. : After this e funeral d	cate	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation (Month, Day	ry 28b. Tin y, Year) 28b. Tin	ne of 28	Bc. Injury work?	4 □ N at	2		esidence 6 Other (Specify) be how injury occurred			
s after dec	Certifi	3 Suicide 6 Could not be		n, street, factory,	street, factory, office 28f.				treet and n, State)	Number or	Rural Route Number,	
he Funera	Medical	29a. Certifier (Check Check only one) 1 Certifying Physician: To the best of Medical Examiner: On the basis of e	xamination and/or in	nvestigation, in m	ny opinior	n, death o	ccurred at	the time, date a	nd place, a	and due to t	the cause(s) and manner stated	
, 9		29b. Signature and title of dertifier	MD ·	29c.	License	number	, 4	-8	29d. Date	signed (M	2/20/>-	
OX		30. Name and address of person who completed cause of d ANNE ARUNDEL MEDICAL	CTR, 20	pe, Print) MA				DAVU:		OLIS	MD-21401	
State Registra		31. Date filed (Month, Day, Year) 32. Registra MAY 0 9 2012	ar's Signature	back	,						,	

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

BERMUZMICHAET305

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

(op co)/		- I Waldull M	
uneral service license	22. Name and Address of Facility Robert 16000 Annapolis Road,		
the disease, or compli art failure. List only one (Final on	cations that caused the death. Do not enter the mode of dying, such as cardiac or respirat	tory arrest,	Approximate Interval Between Onset and Death
	Due to (or as a consequence of):		
onditions, mmediate erlying r injury	Due to (or as a consequence of):		
Last	Due to (or as a consequence of):		
at pregnant 23 months?	3c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of de	rlivery Day Year
ral Fin	itributing to death but not resulting in the underlying cause given in Part I.	Did tobacco use contribute to	
	Starting Polyman Diverse	autopsy prior to performed? performed?	rtopsy findings available completion of cause of
red to medical	26. Place of Death (Check only one	e)	
⊠ No H	ospital:	Residence 6 Other (Spec	cify)
th 5 Pending Investigation 6 Could not be	00 7 6	cribe how injury occurred	
determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Loca City	ation (Street and Number or Ru or Town, State)	ral Route Number,
2 📖 Medical Examine	cian: To the best of my knowledge, death occurred at the time, date and place, and due to er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, Practitioner: To the best of my knowledge, death occurred at the time, date and place, and or	date and place, and due to the	cause(s) and manner stated.
title of certifier C	Hard 29c. License number DZ6287	29d. Date signed (Mont.	h, Day, Year)
ress of person who co	mpleted cause of death (Item 23a) (Type, Print) 7305 Baltman Blvd College	Park Ms	20740
MAY 0 9 201	32. Régistrar's Signature		
	ORIGINAL		

6963

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

19406-1583

1 Yes 2 X No

Ohio

Black, White, etc.

White

State Registrar 4 Homicide

(Check

31. Date filed (Month, Day, Year) MAY 0 9 2012 DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 William Charles Calhoun May 1551 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Y Hours ^{Yea}r) 1929 **Director** 216-22-3071 1 **X** M 2 □ F 82 Yrs. Nov Maryland Usual Residence of Decedent 28a-f show 10a. State the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified Mary1and Anne Arundel Annapolis 1 ☐ Yes 2X No 10e. Street and Number ö 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? with t Funeral 7 Roosevelt Dr. 21401 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3

▼ Widowed 4 □ Divorced Specify: **Black** Completed Year or Dates 1956-59 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4 or 5+) 12th 0 Mail Supervisor Naval Academy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Willie Calhoun Esther Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Calhoun(Son) Roosevelt Dr. Annapolis, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 5-9-12 4 Donation 5 Other (Specify) Maryland Veteran Crownsville, Md. 21. Signature of Funeral Service Licensee Winame Research &cilitSons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events attending physician and for use as the burial-trans Due to (or as a consequence of). resulting in death) Last Physician/Medical Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year signed by the at id be detached for 9 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2 1 Yes 2 No 1 Yes 2 L 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely ☐ Medical Examiner: On the basis of examination and/or investigation, it may opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of 29d. Date signed (Month, Day, Year) D46052 5/09/12 4x/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Arrepolis

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month

Day, Year)

MAY 1 0 2012

State of Maryland / Department of Health and Mental Hygiene

for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 May 19:40 PM Edith Viola Corron Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Elkton Care and Rehab E1kton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Months Days Hours Min Oct. 14,1939 Mary land 72 213-36-9161 Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 No Ceci1 North East Maryland 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 21901 United States 105 George Street permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Medical Examiner Armed Forces?.

1 Yes 2 No Black, White, etc. 5 ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Education Custodian and Mental Hygie 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rose Viola Wright Earl Lewis Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 42 Lincoln Avenue, North East, Maryland 21901 David Corron / Son item 27 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Department of Importants If any injury or once. Chapel Cemetery Elkton, Maryland 5 Other (Specify) 4 Donation 22. Name and Address of Facility Crouch Funeral Home, P.A. 21. Signaty 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or compilerations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final erebro vascular accident Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examir ned by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 🔀 No Month Year Pregnant at time of death 1 ☐ Yes ∠ y g ☐ Unknown 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has build injury in the certificate has build in the certificate has been build in the certificate has build in the certificate has been build in the certificate has build in t autopsy 1 Yes 2 No Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 X No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Later death.

I Director: After th.

'in by the fundamental' 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hororows To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) SHAHNAWAZ KHAN Y, SUITEA, CHESAPEAKECITY MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 2533 AUGUSTINE HERMAN HWY 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrateND#5perINF,5/14/12;BWW,McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May Physician/ Gregory V. Cirincione 07 2012 **2050** [™] Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday 054-28-12135 **Funeral** Days Months Hours 1 **X** M 2 □ F **Director** 01/04/1934 New York 78 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State notified at Director Rockville 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō er than "natural", or items 23a of the Medical Examiner must be Funeral U.S.A. 13609 Arctic Avenue 20853 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Science Applications and Mental Hygiene. is marked other than College (1-4 or 5+) **5+** Elementary/Secondary (0-12) Electrical Engineer International Corp. Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Victor Cirincione Natalie Labazetta Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13609 Arctic Avenue. Rockville. Maryland 20853 Arline Cirincione - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Gate of Heaven Cem. 05/16/2012 | Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licentary 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Multilobar Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Non-Small Cell Lung Cancer Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine for use as the burial-transit Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death a 🗌 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 2 □ No 3 □ Probably 4 ₺ Unknown Pulmonary Embolism Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy perform performed?

1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 4 1 1 ☐ Yes 2 X No ဂ္ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: After 1 5 Pending injury 1 X Natural within 24 hours after death.

To the Funeral Director; Af
completely filled in by the fu ☐ Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, D0068681 May 09, 2012 10 30. Name and address of person who completed cause of ath (Item 23a) (Type, Print) M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910 Charu Maheshwary,

DHMH 17 Rev 06-2011

Registrar

Date filed (Month, Day, Year,

WAY 1 0 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Physician/ М Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 21 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 09/12/ Birthplace (State or Foreign Country) MD Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Hours Min 218-20-5684 93 Director Yrs. 7191 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland other traumatic event, the Medical Examiner must be notified at by Funeral Director MD Kent Chestertown 1X Yes 2 No 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 21620 23a 203 Lincoln Dr. USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify "natural" 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Factory Worker Eastwind Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Aaron Winchester Mary Foreman Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Ralph J. Deaton (Son) 203 Lincoln Dr. Chestertown. 20b. Place of Disposition (Name of #3 M/F BeneficalAssoc 20a. Method of Disposition 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 05/19/201 Burrisville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie 22. Name and Address of Facility MD Bennie Smith FH 855 High St. Chestertown 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ elure To disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events. Examine Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of). resulting in death) Last physician s the burial Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗆 No mans Yes **Division of Vital** 25. Was case referred tournedical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 🔯 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After t 28d. Describe how injury occurred 1 💆 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu 1 Tyes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical (Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death or courred at the time, date and place, and due to the cause(s) and manner as stated 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MS

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day

32. Registar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death MAY 3, DOROTHY VANSANT Year Medical DAVIDSON 2012 3:15 P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>505 RED LION BRANCH ROAD</u> MILLINGTON QUEEN ANNE'S **Funeral** Social Security Number If Under 1 Year Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Director 01/28/1928 215-68-0606 84 MARYLAND Usual Residence of Decedent show 10a. State at Director 10b. County 10c. City, Town or Location 10d. Inside City Limits notified 28a-f MD QUEEN ANNE'S MILLINGTON 1 Yes 2 No ò 10e. Street and Number must be r 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 505 RED LION BRANCH ROAD 21651 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Page 1 and 2 should be filled within 72 hours after er than "natural", or the Medical Examir Completed by 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 ☐ Yes 2 ☐ No 3 Widowed 4 Divorced If Yes, Give 1 Yes 2 XNo Specify: Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 HOMEMAKER marked other OWN HOME Be 17. Father's Name (First, Middle, Last) is marked o 18. Mother's Name (First, Middle, Maiden Surname) 2 <u>JAMES ALBERT VANSANT</u> GRACE PRATT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 CLEM DAVIDSON / HUSBAND 505 RED LION BRANCH ROAD MILLIGNTON, MARYLAND 21651 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ott 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BIBLE CHURCH 05/05/2012 GALENA, MARYLAND 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 370 W. CYPRESS ST. MILLINGTON, MARYLAND 21651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. Listenly one cause on each listen. Interval Between Opet and Death Immediate Cause Final Physician/ disease or condition ermer 5 Medical egeors resulting in death) Examiner Sequentially list conditions Examine in any, leading to infinediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of). burial-tran resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical Box 68760 IF FEMALE 23b. Was decedent pregnant atten Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Pregnant at time of death Yes 2 No Month the g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has 24a. Was an autopsy certificate performed Yes 2 Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital မ Other: this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural s after death.

I Director: Aft
d in by the fun 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npleted (Check within 2 To the I the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0017036

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16055

m.D

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May Nancy Beaver Donalds 2012 6:00p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 232-50-0346 **Director** 1 □ M 2 🕱 F 82 02/25/1930 West Virginia Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring Maryland Montgomery 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 901 Arcola Avenue 20902 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Unknown 14. Race - American Indian Medical Examiner Black, White, etc. ò ģ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural" Completed Caucasian 3 Widowed 4 Divorced Unknown Year or Dates. Unknown 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Unknown Unknown Unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisherships is marked or 2 Unknown Unknown other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Sherry Davis - Guardian 401 Hungerford Drive, 2nd Floor, Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🕱 Cremation 3 🗌 Removal from State Lincoln Crematory 05/16/2012 4 ☐ ponation 5 ☐ Other (Specify) Ft. Brentwood, Maryland 21. Signatury of Funeral S 22. Name and Address of Facility Simple Tribute Funeral & Cremation 1100709 Center, 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Methicillin-resistant Staphylococcus Aureus disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Pneumonia Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 1 Yes 2 2 9 Unknown ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Chronic Obstructive Pulmonary Disease been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown Completed Dementia Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform , page death?
1 Yes 2 No Yes 2X No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 💢 No 1 K Inpatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: After death. 2 🔲 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0068681 May 03, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910

Registrar DHMH 17 Rev 06-2011

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Charu Maheshwary,

MAY 15 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Esther Leah DEITZ May 11 5:00 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery <u> 24 Crest Park Court</u> Silver Spring **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 122-24-2946 Hours 1 🗆 M 2 🖔 F Director 79 Mar. 25, 1933 Pennsylvania 10c. City, Town or Location Director r 28a-f sl notified Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? United States must be Funeral 23a 20903 24 Crest Park Court ral", or items ! 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mollie Nauhaus Sidney Wein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code if Health a 24 Crest Park Court, Silver Spring, MD Leonard L. Deitz, Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Qther (Specify) Judean Memorial Gardens 05/14/12 Olney, MD Forchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Amyotrophic Lateral Sclerosis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 as the l IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Other (specify) Month Dav Year Pregnant at time of death g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? | ≥ been signe should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Ser performed? this certificate 1 Yes 2 No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one examiner? 2 **Y**No Other: မ 4 ☐ Nursing Home 5 🗡 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural
Accident
Suicide iniury 5 Pending 1 Yes 2 No within 24 hours after death

To the Funeral Director: A
completely filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar 29b. Signature and title of certifier

Event a. Acceptor, 01.0.

31. Date filed (Month, Day, Year) MAY 15 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bernard A. Heckman, M.D., 8830 Cameron Street, #405, Silver Spring, MD

29c. License number

D0005373

29d. Date signed (Month, Day, Year)

05-11-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death I. Physician/ Gloria Dacy Manth Manth 10, D2/012 Year 1910 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Montgomery **Examiner** Bethesda Suburban Hospital 8. Date of Birth (Month, Day, Year) 7/17/1930 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 579-38-3872 1 □ M 2 🏲 F **Director** 81 Wash., D.C. Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Kensington 1 XYes 2 No MD Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3129 University Blvd, West Funeral 20895 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc þ 1 🛭 Never Married 2 🗆 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hair/Cosmetics Beautician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Amelia Kotoch Alexander Dacy 19a. Informant's Name/Relationship (Type, Print) Tormer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7425 Democracy Blvd.#211 Bethesda, Md20817 Ann Dacy/sister-in-law Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5/14/2012 Wash., D.C. 4 Donation 5 Other (Specify, Glenwood Cem. uneral Service PHYTE TPACTS REWALDI FUNERAL SERVICE, P.A. 21. Signatur. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. day's Death Immediate Cause (Final Physician/ Subdural hematoma disease or condition Medical resulting in death) Due to (or as a consequence of) mo **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Q Exami attending physician and for use as the burial transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery Dog 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 \(\sum \) Yes 2 \(\begin{array}{c} \boldsymbol{X} \) No Dav Pregnant at time of death signed by the a ld be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cirrhosis, renal failure 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has to page 2 s autopsy performed? Yes 2 K No this certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death, funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 🗌 No 1 X Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 🛣No 27. Manner of Death 28b, Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After Natura.

Accident 5 Pending 4/28/2012 0001 fell out of bed Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3129 Iniversity Blvd.W, Kensington, Md filled in by determined at home Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d, Date signed (Month, Day Yea, 29c. License number MM122 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road Bethesda, MarylaND eigh BOV notein 31. Date filed (Month, Day, Year) State MAY 1 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 13. Luigi DiStefano 2012 10:50 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1760 Woodstock Rd. Woodstock Howard Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days Hours Min. **Director** 215-44-2194 1**X** M 2 ∏ F 68 12/19/1943 Italy Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location the Maryland Examiner must be notified at 10d. Inside City Limits Director MD Howard Woodstock 1 Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1760 Woodstock Road 21163 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 'natural", or 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1964-70 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Accountant US Government marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ൧ Pasquale DiStefano Rosalia Piraino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a <u>Venera D. DiStefano - Wife</u> Woodstock, MD 1760 Woodstock Road item, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or of Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 05/17/2012 Timonium, MD Dulaney Valley Cem. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 Shem Collin-10th 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastastic Ancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to imm, if the cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Due to (or as a consequence of): burial-t resulting in death) Last the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 N 1 Yes funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 2/28/ 600 N. Wolfe Street,

124

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day, Year)

1 5 2012

DHMH 17 Rev 1/2001

State Registrar Mary G. Ripple MD.

31. Date filed (Month

900 W. Baltimore Street, Baltimore, MD 21223

Deputy Chief Medical Examiner

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APR JASON KYLE EDENS 2012 3:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY BETHESDA WALTER REED NATIONAL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 🛛 M 2 □ F Hours Jume^{th,} 6^{ay, Y}1989 Tennessee 415-63-0498 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified TN Williamson Franklin 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 1016 Moran Road 37069 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ² No 2009 ² No 2012 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Soldier US Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Janet Sue Harpool James Edward Edens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashley Edens/Wife 1016 Moran Rd. Franklin, TN 36069 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harpeth Hills Men Carden 20c. Location - City or Town, State Date 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State May 5, 2012 Nashville, TN 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral vervice Dicennee 22. Name and Address of Facility Murphy FH 45<u>10 Wilson Blvd.</u> VA 22203 Arl 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ GUNSHOT WOUND TO THE HEAD disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.

Funeral Director: After this certificate has been sinned by the attending objustical. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1

Yes 2 □ No 24a Was an cate has l performed? funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 XYes 2 □ No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pendina 1 XYes 2 No 2 Accident
3 Suicide SMALL ARMS FIRE Investigation 04/15/2012 8:10 A^{M} within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 X Homicide determined AFGHAN ISTAN LOKAY VILLAGE Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) VA 0101102718 APRIL, 27, 2012 oleman OUR ME UST

Registrar
DHMH 17 Rev 7/2009

State

CAROL

WALTER REED NATIONAL MEDICAL CENTER

BETHESDA, MD 20889

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SOLOMON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 9 Robert Benjamin Edwards 2012 12:02 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Anne Arundel Medical Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funera! 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Director** 578-46-9864
Usual Residence of Decede 75 May 9, 1937 Washington, DC show or 28a-f shov notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 X No 10e. Street and Number 10f. Zip Code č 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 2517 Painter Court 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 - Widowed 4 - Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Continental Elementary/Secondary (0-12) College (1-4 or 5+) Route Salesman 12th Baking Company be filed v Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic « once. William Edwards Althea Louise Haas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2517 Painter Court, Annapolis, Maryland 21401 Paige Edwards/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 5/14/12 Davidsonville, MD 21. Signatu 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ear Medical Due to (or as a cons ou nce of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injure that initiated events resulting in death) Last physician ar Due to (or as a consequence of) Physician/Medical P.O. Box 68760 as attending p IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Year ed by the a detached f 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed has this certificate Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After work?
1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wrott

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 7, Physician/ 2012 11:30 A M Mary Jane Foley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 3401 Greenway #104 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday, **Funeral** 83 115-20-4527 Director 1 M 2 X F New York 10/8/1928 items 23a or 28a-f show er must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must ha matitied at 10b. County 10c. City, Town or Location Director Baltimore 1 Yes 2 ☐ No Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21218 3401 Greenway #104 . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 K No Specify. Specify: White If Yes, Give Year or Dates 3 🗓 Widowed 4 🗆 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) State of Maryland Social Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ukn ည Margaret Burns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 6568, Annapolis, MD 21401 Dan Foley - Son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 5/11/2012 Baltimore, MD Baltimore Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee Regelini. 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line MON A one and Death Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abusing made Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown neart 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 2 🗌 No 1 Yes Yes etely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 2 No 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29b. Signature and title of certifier 2012

CAS

State Registrar 31. Date filed (Month, Day

2012 32. Registrar's Signature 1. January 1.

cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

				-	Print in								e Legible) <u>.</u>		
	1	For State Registrar			,		Certifica					Reg. No	201	2	169	7
Physician	/	1. Decedent's Name (First, Midd Ralph	E .				Forn	wa1d			2. Date of Domestin Month May	D	ay Year		3. Time of Death 5:30 pm	VI
Medica Examine		4a. Facility Name (if not institution 7827 Rocky Ri					Thu	y, Town, or	t				c. County of Dec	k		
Funeral Director		5. Social Security Number 220-16-3602	6. Sex	M 2 □ F	7. Age (In yrs. 87	last birthd	Months	ler 1 Year s Days	If Under Hours	24 Hrs. Min.	8. Date of Bi Aug 30		9. B 24 Was	rthplac puntry) nin {	e (State or Foreig Ston, D. C	jn •
th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. Count Maryland Fred 10e. Street and Number	ericl			ty, Town o		Zip Code	0			_	itizen of What C		Inside City Limit 1XX Yes 2 1	
ter dea	र्व	7827 Rocky Rid 11. Marital Status 1 Never Married 2 X N	12 arried		2 No	.S.	If Yes, sp	edent of Hecify Cuba	ispanic Or an, Mexica	n, Puerto	ecify Yes or No Rican, etc.)		SA 14. Race - Am Black, Wh Specify:	te, etc.	indian,	
vithin 72 hours iene. r than "nattir the Medical B	Completed	15. Deced (Specify only hig Elementary/Seconday (0-12)		ation)	(C	ecedent's Us Give kind of w Fe. DO NOT u	vork done (ise retired)	during mos	st of work	ing		Kind of Business Industry Detrick			
l be filed v lental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Charles Fornwald 18. Mother's Name (First, Middle, Maide Hilda Carlson							en Surname)							
d 2 should alth and M 1 27 is ma ir trauma		19a. Informant's Name/Relation Douglas Fornwa											or Town, State, 2 dge, Ma		e) and 2177	'8
Page 1 and tment of He tant: If item jury or othe		20a. Method of Disposition 1 Burial 2 □ Crematic 4 □ Donation 5 □ Other	(Specify)	emoval from	State	cemetery,	oisposition (Natural Control of C	r other place emete	ry			Thu	rmont,	Mar		
permit Depar Impor any in		21. Signature of Funeral Service	tieensee	. 10-			22. Name						neral H ick, Ma		and 217	70
Physician/ Medical		23a. Part 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	or complice t only one	cause on ea	caused the dea	(lens)	enter the mo	ode of dyir	ng, such as	cardiac	or respiratory a	arrest,		Al	oproximate terval Between nset and Death	_
ia ex	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b.	Due to	(or as a conse	quence of)	:									
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the burneral director.	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23	1 Live	tcome of pregr Birth 2 Fe gnant at time o nown	tal death	3 Ectopi 5 Other		су				23d. Date of o	lelivery Da	y Year	
ires that the signed by		Part II. Other significant cond Type 7 Chronic	itions cont	ributing to d	death but not re	esulting in	the underlyin	ig cause gi	ven in Par	t I.			use contribute		cause of death?	wn
he law requ te has beer age 2 shou	Completed	Chronic	Kia	lvey	Dices	ı					_ per	s an opsy formed?	prior to death	o comp	findings availab letion of cause o	le f
ian: T rtifica ctor, p	Be C	25. Was case referred to medic examiner?								ath (Ched	ck only one)					_
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the Hos ithin 24 ho the Fund ompleted 1	Medical	(Check 2 Medica only one) 3 Certify	I Examine ing Nurse	r; On the ba Practioner:	sis of examinat To the best of	ion and/or i	investigation, dge, death od	in my opini curred at the	ion, death one time, da	te and pla	at the time, date ace, and due to	the cause	ce, and due to the control of the co	e cause as state ath. Dav		ate
5 ≥ 5 8		1	90	m,	no			00	0351	152			5-10-1	2		
10x1		30. Name and address of persons of the state	on who cor	npleted cau	se of death (Ite	em 23a) (Ty	rpe, Print)	7	Lyan	nont	MD	2	1.788			
Stat Registra		31. Date filed (Month, Day, Year	1 20	32.1	gistrar's Sigr	nature	barre	4								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ada Mary Fox MAY 2011 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Boonsboro Reeder's Memorial Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2XXF Hours Min. July 25, 1918 ^{Country}ginia 217-09-9566 **Director** 93 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Williamsport 1 X Yes 2 ☐ No Washington Maryland ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21795 USA 326 Coneflower Drive items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1XXNever Married 2 Married Yes 2 X No Yes, Give ō Completed by ME: FOX ADA M. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. "natural" 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important. If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Medical 10 Receptionist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Miller Samuel Nathan Fox Tennia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21713 19613 Shepherdstown Pike Boonsboro, Maryland Erval Cochran - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗴 Burial 2 🗆 Cremation 3 🗆 Removal from State Lawn Mem. Park | May 16,2012 | Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Higensee 21795 Deburned Tuner fallity Home, P.A. 425 S. Conococheague St. Williamsport, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARTERIOSCLEROTIC CARDIOVASCULAR disease or condition YRS Medical resulting in death) Due to (or as a consequence of): DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) g Unknown detached 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ LTPERTENSION MY PERKICIDEMIA Division of Vital Records, cate has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed DEMENTIA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? certificate 1 ☐ Yes 2 ☐ No or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Vursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this n 24 hours after death.

e Funeral Director: After the bleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Tes 2 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🖰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b, Signature and title of certifier 29c. License number 00018019

State Registrar STREET, HAGERSTOWN

MAY 10, 2012

MAZY, AND 21740

and mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

340

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month <u>John Josep</u>h Foley 05/07/2012 11:00 pM Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Mt. Airy, Maryland Kline Hospice House Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 1**X** M 2 □ F 81 77-24-4205 Pennsylvania 10/14/1930 Usual Residence of Deced 28a-f show 10c. City, Town or Location at 10a. State 10b. County 10d. Inside City Limits the Maryland Director notified 1X Yes 2 ☐ No Rockville Maryland Montgomery 10f. Zip Code 5 10e, Street and Numbe 10g. Citizen of What Country? Examiner must be 23a Funeral vith. U.S.A. 20850 #307 701 Falls Grove Dr. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced ō þ 1 Yes 2 No If Yes, Give Year or Dates. filed within 72 hours after altimore, Maryland 21215-0036 1358 1 Yes 2X No Specify. "natural", Specify: White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Self Employed Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h .. Page 1 and 2 should be fill tment of Health and Mental tant; If item 27 is marked o ၉ Alice Catherine Nangle traumatic James Vincent Foley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Joyn, State, Zip Code) 5181 Almeria Ct. Mt. Airy, MD 21771 Ruth Riley (Daughter) other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If it any injury or o St Peter the Apostle 05/14/2012 Libertytown, MD Donation 5 Other (Specify) 22. Name and Address of Facility Hysong Company SignAture of Funeral Service LC 00 2222 Wisconsin Ave. Washington, DC 20007 /cc0367 Ovcomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, ovcompli shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy page 2 this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one. Be Other: 4 Nursing Home 5 Residence ė 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 5 Pending 1 Natural work?
1 Yes 2 No Accident Investigation completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Within 2 To the F 3 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) mpleted cause of death

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Marylan Registrar		artment of H			2	012	16980		
			Decedent's Name (First, Middle, Last)		anoute of B	2. Date of Dea	Death 3. Time of					
	Physicia Medic		LORRAINE ANN FRICKA				MAY	5 Day	2012	4155PM		
and a	Examin	er	4a. Facility Name (if not institution, give street and number) TAYLOR MELFA HOUSE		4b. City, Town, or DENTON	Location of Death			nty of Death			
	uneral		5. Social Security Number 6. Sex 7. Age (In yrs. In	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Date of Birth 9. Birthplace (State or Foreign Month, Day, Year) Country)				
	irector		007-01-2685 1 □ M 2 🖾 F 93 Usual Residence of Decedent	Yrs.			09/20/1	.918	MAI	NE		
yland	-f sho ed at	ctor		y, Town or Loc					10	d. Inside City Limits		
те Ма	or 28a notifi	Director	DE KENT 10e. Street and Number	HARRIN	GTON 10f. Zip Code			10- Oili	of What Countr	1 Yes 2 No		
with t	s 23a (ust be	Funeral	55 LOBO ROAD		1995	2		0	ED STA	*		
death	r item iner m		11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Yes 2 No 194	3. 13. V	Was Decedent of His f Yes, specify Cuban	spanic Origin? (Spec , Mexican, Puerto F	cify Yes or No- Rican, etc.)		ace - America lack, White, et			
15-0036 72 hours after death with the Maryland	ral", o Exam	ed by	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never No. 194 3 Never Married 2 Married 1 Never No. 194 If Yes, Give Year or Dates, 194		∏Yes 2 X No	Specify:		Specia				
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2121 within 7	r than	Com	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO	O NOT use retired) CIATE EDI'			NEWS				
and 2	d othe		17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, N					
ryla i	narke natic e	၀	FRED PARKER RICH				TA DALI					
Maryl 12 should	27 is m r traum		19a. Informant's Name/Relationship (Type, Print) DEBORAH A. REMENTER/DAUGHTER		ng Address (Street ar OBO ROAD,				State, Zip Co	ode)		
ore, M	tron result and western ryperier. Them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 20b. P	Place of Dispos	sition (Name of		ate ate		n - City or Tow	n, State		
Baltimore, Maryland 21215-0036 Demit. Page 1 and 2 should be filed within 72 hours after	Important: If item any injury or other once.		4 Donation 5 Other (Specify)	SAPEAK CEN	E CREMATI TER	ON 05/08	/2012	STEVEN	SVILLE	, MD		
Balti permit.	Important any injury once.		21. Signature of Funeral Service Licensee	FF 10	LLLOWS, HE	LFENBEIN K ROAD.	& NEWN.	AM FUNI	ERAL HO	OME, P.A.		
			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.		_				í	Approximate Interval Between		
-	aician/ ledical		Immediate Cause (Final disease or condition resulting in death)		ROTTO C	ARDIDVA	BOUGHL	DISER	00	Onset and Death		
	aminer		Due to (or as a consequ	ience ot):						,		
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xecute	al-tran	Exar	Cause (Disease or injury that initiated events c	uence of):								
60 ate be e	ysiciar ne buri	dical	L d									
3876 rtificat	ing ph e as th	/Mec	IF FEMALE:	3								
ox 6	attending physician and I for use as the burial-transit	cian/	23b. Was decedent pregnant in the past 12 months? In Was 2 Mo 4 Pregnant at time of c	al death 3	Ectopic pregnancy Other (specify)				Date of delivery	y Day Year		
O. The de	by the	Physician/Me	1 Yes 2 No 4 Pregnant at time or o	outi o L	Other (opeony)							
Records, P.O. Box 687 The law requires that the death certifics	gnec be d	by	Part II. Other significant conditions contributing to death but not res	ulting in the ur	nderlying cause give	n in Part I.		_	_	cause of death?		
ords require	peen s	Completed	THE THIS PIDEN	26			1 L Ye			bly 4 Unknown y findings available		
ecc	has je 2	omp					autops	med?	prior to comp death?	pletion of cause of		
al F	certificate irector, pag		25. Was case referred to medical examiner?		26. Plac	ce of Death (Check	1 \(\sum \) Yes : only one)	2 SNo	1 Yes 2	□ No		
F Sit	this ce al dire	욘	1 Yes 2 No Hospital:		t 3 DOA Other	4 Nursing Hon	ne 5 🗆 Reside	ence 6 🗆 Ot	her (Specify)			
oding F	After	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury a work? M 1 🗌 Y	at 2: 'es 2 \sum No	8d. Describe ho	w injury occur	red			
Division of Vital tall or Attending Physician:	rector by the	ertifi	3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At hobididing, etc. (Specify)				8f. Location (Str		ber or Rural R	oute Number,		
Divided of the purs after the purs a	eral Di					1	City or Town					
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this completely filled in by the funeral di	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge of the desired from the	and/or investi	igation, in my opinion	, death occurred at t	he time, date and	d place, and di	ue to the cause	e(s) and manner stated.		
Jo t	To 1		29b. Signature and the orgentifier PLEMSEW MO		29c. License r	14664		9d. Date sign	ed (Month, Da	y, Year)		
51	m5		30. Name and address of person who completed cause of death (Item		rint)			100	21/2	70		
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signat	ure		DEN	CON	VIII	216	47		
	Registra		MAY - 8 2012 Censur	B. 7	park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ₹o/s Howard Fried 1025 Stanley 20 00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mome brein Kurll monl Omery JC If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Sirthplace (State or Foreign **Funeral** Months Davs Hours Worth 23 1931 144-22-2471 81 New Jersey Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d, Inside City Limits iral", or items 23a or 28a-f shorex Examiner must be notified at Director Rockville 1 Yes 2 X No Maruland Montgomery 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 20852 5801 Nicholson Lane, #1814 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify: If Yes, Give Year or Dates "natural", 3 Divorced 4 Divorced 1955 White Completed injury or other traumatic event, the Medical Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene.
7 is marked other than "r College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Chief of Real Estate Department of Defense Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Frederick Fried Sallu Fisch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 5801 Nicholson Lane. #1814. Rockville. MD 20852 Nanette Fried - Spouse 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place. 1 X Buria! 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Judean Memorial Grdns 05/10/2012 Olney, Maryland 21. Signature of Funeral Service Licenses 14101564 22. Name and Address of Facility Hines-Rinaldi Funeral Home, atri 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ DIOMYOPATT disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ORONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): m e attending physician and The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 01 Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death signed by the a d be detached for 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 24 No 3 Probably 4 Unknown Completed FEMORAL NECK FRACTURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy certificate Yes 2 Division of Vital 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗌 No ည 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: After 5 Pending 1 Natural 2.30 AM Accident 03/24/2012 Investigation within 24 hours after death

To the Funeral Director.

Completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5 801 NICHOLSON LANE ROCKNILLE, MD determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) D0061096 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONTROSE ROAD ROCKYILLE 6121 APA

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 0 2012

Registrar's Signature

	-	For State	State of Mary		partment of F ertificate of L		-		201	0 1000
		Registrar 1. Decedent's Name (First, Middle, Last)		C	erunicate of L	Death	2. Date of De	Reg. No.	201	7 1698
icia		Eleftheria	Balitsaris]	ortier		Month May 8		2 Year	3. Time of Death 10:29 A M
edic min		4a. Facility Name (if not institution, give si	treet and number)			r Location of Death		4c. 0	County of Dear	
al		8701 Hempstead A		yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Bir	th	9. Bir	thplace (State or Foreign
r		129-30-4759 Usual Residence of Decedent	JIVI Z LAT	84 Yrs.	,		Jan. I	1,192	8 33	Greece
once,	tor	10a. State 10b. County	10	lc. City, Town or I	ocation					10d. Inside City Limits
	.=	Maryland Montgome	ry	Bethes						1X Yes 2 □ No
l	ai D	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	ountry?
l	Funeral	8701 Hempstead Ave			20817				SA	
		11. Marital Status 1 ☐ Never Married 2 🛣 Married	12. Was Decedent Ever Armed Forces?	in U.S. 13	. Was Decedent of H If Yes, specify Cuba			1	 Race - Ame Black, White 	
١	d by	3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates.		1 ☐ Yes 2 🗶 No	Specify:		s	pecify: Wh	nite
	lete	15. Decedent's Edu	ication		edent's Usual Occup			16b. Kin	d of Business	Industry
ĺ	Completed	(Specify only highest grad Elementary/Seconday (0-12)	completed) College (1-4 or 5+)	life.	e kind of work done o DO NOT use retired)		king			
1		12		F	lomemaker			70	wn Home	2
1	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan			ımame)	
1		Panayotis Balits				Pepits	a Kazant	zi		
		19a. Informant's Name/Relationship (Typ		I .	iling Address (Street					
J		Roger Fortier/ F 20a. Method of Disposition			Hempstea	ad Ave.,	Bethesda			
1		1 ☐ Burial 2 X Cremation 3 ☐ F	Comoval from State	cemetery, cr	ematory or other plac	^{ce)} May 20	9 13		ation - City or	
ı		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses		Metropol Cremator	y Name and Addres					, Virginia
		Miria Hall	M.		22. Name and Addre					, DC 20007
İ		23a. Part 1. Enter the disease, or compli	cations that caused the		-				Ingcon	Approximate
ı		shock, or heart failure. List only one Immediate Cause (Final								Interval Between Onset and Death
'		disease or condition resulting in death)	. Cardiac Due to (or as a co							
ı		Conventially list conditions	Atheros	scleroti	c Vascula	r Disease	2			10 Years
١	Examiner	Sequentially list conditions, if any heading to immediate cause. Enter Underlying	Due to or as a co							
۱,	xam	Cause (Disease or iinjury that initiated events								
- 1		resulting in death) Last	Due to (or as a co	nsequence of):						
1	dic	d	l							
1	_	IF FEMALE:	3c. If yes, outcome of p	regnancy						
ĺ	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 2 4 Pregnant at tim	Fetal death 3	☐ Ectopic pregnand☐ Other (specify)	су		23	3d. Date of de Month	Day Year
١	ysi	1 Li Yes 2 Mo 9 Li Unknown	9 Unknown	10 01 000111						
١	by PI	Part II. Other significant conditions con	tributing to death but n	ot resulting in the	underlying cause given	ven in Part I.	23e. Did to	obacco us	e contribute to	the cause of death?
l	g p€						1 🗆	Yes 2 🔀	No 3 🗆 P	robably 4 🗆 Unknown
İ	Completed						24a. Was			topsy findings available
ı	E O						autor	rmed?	death?	completion of cause of
-1		25. Was case referred to medical	<u> </u>		26. PI	lace of Death (Chec	1 🗌 Yes	2 & J No	I □ Yes	s 2 No
		examiner? 1 Yes 2 No	ospital:	2 🗌 ER/Outpati	Oth	er:	ome 5 K Resid	dence 6	Other (Spec	eify)
l	<u>В</u>		28a. Date of injury (Month, Day, Ye	28b. Time	of 28c. Injury	y at	28d. Describe h			
l	၉	27. Manner of Death				Yes 2 No				
	၉	1 Natural 5 □ Pending Accident Investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
	၉	1 🛂 Natural 5 🗌 Pending	28e. Place of Injury - building, etc. (S		treet, factory, office		28f. Location (S City or Tow		Number or Ru	ral Route Number,
	Certificate: To	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	pecify)			City or Tow	n, State)		
	Certificate: To	1 ☒ Natural 2 ☐ Accident 3 ☐ Sulcide 4 ☐ Homicide 29a. Certifier (Check 2 ☐ Medical Examine)	28e. Place of Injury - building, etc. (S)	pecify) knowledge, deatlination and/or inve	n occured at the time	on, death occurred a	City or Town nd due to the caut the time, date a	use(s) and	manner as sta	ated. cause(s) and manner stated.
	Medical Certificate: To	1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 29a. Certifier (Check 2 ☐ Medical Examinations) only one) 1 ☒ Certifying Physic	28e. Place of Injury - building, etc. (S	pecify) knowledge, deatlination and/or inve	n occured at the time estigation, in my opinion, death occurred at the	on, death occurred a ne time, date and pla	City or Town nd due to the caut the time, date a	use(s) and and place, a e cause(s)	manner as sta and due to the and manner as	ated. cause(s) and manner stated stated.
	Medical Certificate: To	1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 29a. Certifier (Check 2 ☐ Medical Examinationly one) 3 ☐ Certifying Physic	28e. Place of Injury - building, etc. (S)	pecify) knowledge, deatlination and/or inve	n occured at the time estigation, in my opinio, death occured at the 29c. License	on, death occurred a ne time, date and pla	City or Town nd due to the caut the time, date a	use(s) and and place, a e cause(s) a 29d. Date	manner as sta	ated. cause(s) and manner stated stated. h, Day, Year)

State

Pasquale Santini, MD, 5530 Wisconsin Ave, #1400, Chevy Chase, Md. 20815
31. Date filed (Month, Day, Year)
MAY 1 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 6983 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Gersdorf 2012 7:15 A M Gertrud May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Hanover Morningside Assisted Living If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. g. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 87 065-32-2510 Director 1 □ M 2 🛣 Nov. 28,1924 Germany r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State Director Baltimore Anne Arundel 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò must be 23a Funeral USA 21226 404 Carvel Beach Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or iten edical Examiner n Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working ed other than " event, the Med Art traumatic event life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Architecture 4 <u>Architect</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ပ Balbina Otto Gersdorf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 404 Carvel Beach Road Baltimore, MD 21226 Priscilla Palmiter / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) May 11 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite metro Crematory, INC. 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 0 2012 Baltimore, MD injury (21 Signature of Funeral Service Lice ee 22 Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy, Severna Park Funeral Home Severna Park, MD 21146 P.A. 3a. Part 1, E, ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterval Between Set and Death Immediat Cause (Final disease r condition Physicani men Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Petal death Pregnant at time of death Ectopic pregnancy for in the past 12 months? Day 5 Other (specify) Yes 2 No ed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed be should be det Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an ate has I prior to completion of cause of performed 2 2 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 10 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify 27. Manne of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending n 24 hours area ware he Funeral Director: Aff 1 Tes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 3 🗆 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Dav. Year)

istrar's Signature

Madwa

AACO Health Dept. 5011-12 KAH State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 902 p M 0 groaner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday Social Security Number 201–14–5934 **Funeral** 85 Director 54-7039 1 M 2 XX 201 7/30/1926 PA Usual Residence of Decede or 28a-f show 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. Count item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes XX No Annapolis Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21403 7101 Bay Front DR. Apt. 518 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2xx Married þ Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2XXNo Specify. Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) High School Teacher 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jessie Horawitz Samuel Brouder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, MD 21403 7101 Bay Front Dr. Apt. 518 Husband <u>Paul Grodner</u> Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/10/2012 Annapolis, MD Hillcrest Memorial 22. Name and Address of Facility Hardesty Funeral Home, 12 Ridgely Ave. Annapolis, MD 21401 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physiciani Se disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Physician/Medical Examine Due to (or as a consequence of) use as the burial-transi Cause (Disease or injury The law requires that the death certificate be executed l a that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) Pregnant at time of death be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death?

1 Yes 2 No has 2 2 Yes Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ER/Outpatient 3 DOA မ 1 🗹 inpatient 2 🗌 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 1 / Natural 5 Pending 2 🗌 No Accident Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00054903 Mi) 2012 Annupolis address of person who completed cause of death (Item 23a) (Type, Print) 139 Old Solomons Lar mi rederic Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend No.5 per FD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

655 	-1-1-	Please Type or Print in Black Inde	lible Ink. Ensu	e All Copies	Are Legib	le. 20	12 69
ey Grossnic	1- I Re	For State Of Maryland / Departing	nent of Health ar cate of Death	io Mentai riyg	Reg. No		
Physician cal Examine	er (Decedent's Name (First, Middle,Last) Geoffrey Allen Grossnickle			Date of Death Month Day May 12, 2012		3. Time of Death 1928 hrs
	4a	Facility Name (if not institution, give street and number) Frederick Memorial Hospital	4b. City, Town, o Frederick	Location of Death		c. County of Dea Frederick	ath
Funeral Director		Social Security Number 6. Sex 7. Age (In yrs. last bi	irthday) If Under 1 Yea Months Day	s Hours Min,	B. Date of Birth(MN 06/20/19	For	Birthplace (State or eign Country)Marylan
109	_	ual Residence of Decedent a. State 10b. County 10c. City, Town	n or Location				10d. Inside City Limi
aryland Sa-f show at ooce.	b M	aryland Frederick W	oodsboro				1 Yes 2 X
th the Maryland 23a or 28a-f sho uotified at ooce.	100	e. Street and Number	10f. Zip Code		10g. Ci	tizen of What Co	ountry?
ith the		1015 Keymar Road Marital Status 12. Was Decedent Ever in U.S.	2179			ted Sta	
and 2 should be filed within 72 hours after death with the Manyland teath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examicer must be notified at once TO Re Commission by Eumoral Discretors	≖ I	Never Married 2 Married Armed Forces? 1 Yes 2 X No		n, Mexican, Puerto Ric		White, etc.	erican Indian, Black,
ral", o	3 اچ	Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No			Specify: V	Vhite
"natural		5. Decedent's Education (Specify only highest grade completed) 16a. Elementary/Secondary (0-12) College (1-4 or 5+)	. Decedent's Usual Occupa during most of working life			Kind of Busines	s/Industry
led within 72 Hygiene. I other than the Medical		12	n/a			n/a	
Hygien d other		Father's Name (First, Middle, Last)		18.Mother's Name (F			
should be filed with and Mental Hygiene. 7 is marked other ti natic event, the Mec		obert L. Grossnickle, Sr.	9b. Mailing Address (Stree	Anna L. N			to Zin Codo)
27 is umatic		Vi.	8 E. George				
permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati		n. Method of Disposition 20b. Place	of Disposition (Name of ce atory or other place) Stnaven	metery, D	ate 20c.	Location - City	
Page ment o tant: or oth	4	Donation 5 Other Specify: Memo	rial Gardens	May 1	012 Fr	ederick	, Maryland
Depart Impor	21.	Signature of Figure al Service Doensee	22. Name and Address Resthaven	of Facility Funeral Se	rvices,	Skkot C	ody P.A.
nysician	238	Part I. Enter the disease, or complications that caused the death. Do n	19301 Catoc	tin Mounta	ıın Hwv.	Frederi	ck, MD 2170
Medical	19	failure. List only one cause on each line. nediate Cause (Final disease a Probable Drug Int					Between Onset an Death
caminer	or	condition resulting in death) Due to (or as a consequence of):	·				
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ted Insit Examiner	cau (Di	ise. Enter Underlying Cause sease or injury that initiated c					
an and al - transit	eve	onts resulting in death) Last Due to (or as a consequence of): d.					
6 2 2 2		© UNPENDED □ AMENDED 23a,27,28a	-f,per me,g9	28 6-8-12	sm		
g physisthe bu	IF F 23b.	EMALE: Was decedent pregnant in the 23c. If yes, outcome of pregnancy		75		d. Date of delive	•
the death certificate be ex by the attending physician ched for use as the burial - Physician/Medic	1	past 12 months?	Fetal death 3 Other (Specify)	Ectopic pregnancy		Month	Day Year
s that	2	t II. Other significant conditions contributing to death but not resulting	ng in the underlying cause o	iven in Part I.			o the cause of death?
	n blefe				24a. Was an autopsy performed?		autopsy findings availab completion of cause of
ificate	25	Was case referred to medical	26 Place	of Dooth (Charles at	1 ✓ Yes 2 N	lo 1 🗸 Y	
r this certinal director	5	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/O		of Death (Check only Other, Nursing H	ome 5 Reside	ence 6 Othe	er.
After t uneral		Manner of Death 28a. Date of Injury 28b.	Time of Injury 28c. Injur	· .	f. Describe how inj	ury occurred	
death. ctor: y the f	2	Accident Pending Investigation fd 5-12-12 fd	8:00 am		known		
spital or Atteodiog hours after death. ocral Director: After filled in by the fune Certification:	3 4	Suicide 6 X Could not be determined Specify Found at		0.	Location (Street a or Town, State) odsboro,	11015 Ke	tural Route Number, Cit ymar Rd.
To the Hospital or Atteoding Physiciae: The I within 24 hours after death. To the Fuoeral Director: After this certificate I completely filled in by the funeral director, page Medical Certification: To Be Com		Certifier 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or in and manner stated.	eath occurred at the time, da investigation, in my opinion	ite and place, and due , death occurred at the	to the cause(s) are time, date and pla	nd manner as sta ace, and due to t	ated. the cause(s)
W	29b	Signature and title of certifier 2000 1000 1000 1000 1000 1000 1000 100	29c. Licens O.C.I			Date signed (Me	onth, Day,Year)
		Name and address of person who completed cause of death (Item 23a)	-				
9		Victor Weedn MD JD Assistant Medical Examiner	900 W Baltimore S	treet Baltimore	MD 21223		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #25,27,28A-F, PER ME G928,6/28/12 TRT
For Per ME G928 6/28/12 TRT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mara Day Arnold Francis 15 1:45PM Gozora 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Davs Hours Director 144-18-0449 1**XX**M 2 □ F 88 Jan. 23, 1924 New Jersey Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 No Maryland Washington Williamsport 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 10606 Oak Tree Circle 21795 USA 'natural", or items death 12. Was Decedent Ever in U.S. Armed Forces? X Yes 2 No 1943- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or is any injury or other traumatic event, the Medical Examine once. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify. Completed 1946 White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 3 Machinist Truck Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine Paul Ference Gozora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10606 Oak Tree Circle Williamsport, Maryland 21795 Katherine Gozora - Wife 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Greenlawn Mem. Park May 19,2012 Williamsport, Maryland 4 Donation Other (Specific of Fun al Service Li 22. Name and Address of Facility Osborne Funeral Home, P.A. Signatur #25 S. Conococheague St.Williamsport, Maryland 217\$5 23a. Part Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physicil w/ (Ell disease or condition Medical resulting in death) Dué to (or as a consequence of): Examiner Sequentially list conditions, if any reading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the as attending 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Month Day Year detached Yes 2 No the g Unknown 9 Unknown P.0. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed Yes 2 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 X Yes 2 100 Hospital: Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at I or Attending Fafter death. 28d. Describe how injury occurred Director: After 5 Pending work? 1 ☐ Yes 2 **X** No 2X Accident MAY 12, 2012 UNKNOWN SUBJECT FELL Investigation filled in by the 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural City or Town, State) 10606 OA WILLIAMSPORT, MD OAK TREE CIRCLE determined To the Hospital within 24 hours a To the Funeral C completely filled HOME Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifier nen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W-7+1 Ille medical 32. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 = For State Registrar	State of M	arylan		rtment of H		ind Me		giene Reg. No.	201	2 16987
	Physici	20	1. Decedent's Name (First, Middle, L	_ast)						Date of De Month	Day	Year	
	/Medic		Emma Grace Ge							May	16,	201	
7	Examin	er	4a. Facility Name (If not institution, g)		4b. City, Town, or		f Death			County of De	
_			Golden Living (5. Social Security Number 6.		ae (In vrs.	last birthday)	Hagerst If Under 1 Year	If Under 2	24 Hrs.	8. Date of Bir	th Wa	shingt 9. B	nthplace (State or Foreign
	Funeral Director		213-18-8237	1□M 2 X F	9		Months Days	Hours	Min.	8. Date of Bir (Month, Da 12/04/	1920	1	(Country) MD
	טי		Usual Residence of Decedent		10- 0"	-							Table to the City Limits
	arylar ehow	_	10a. State 10b. County			y, Town or Lo							10d. Inside City Limits 1X Yes 2 ☐ No
	28a-1	Director	MD Washin	gton	На	gersto	Vn 10f. Zip Code				10a Citiz	en of What (Country?
	with	급	750 Dual Highwa	av			2174	ι Ο				JSA	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	death me 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.	.S. 13. \	Was Decedent of H	ispanic Orig	gin? (Spec	offy Yes or No		4. Race - Am	encan Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 ie marked other than "natural", or Iteme 23a or 28a-1 ehow may injury or other traumatic event, the Medical Examinar risks the multiple at ance.	by Fur	1 ☐ Never Married 2 ☐ Married 3 🏧 Widowed 4 ☐ Divorced	Armed Forces? t Yes 2 If Yes, Give Year or Dates:			f Yes, specify Cuba 1 ☐ Yes 2🛛 No	Specify:	, Puerto F	iican, etc.)		Black, Wh Specify:	White
o o	72 ho	Completed	15. Decedent's (Specify only highest of			(Give	dent's Usual Occup	durina most	of workin	a	16b. Kin	d of Busines	s/Industry
2	ithin 196.	np du	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT use retired	d)			τ.	ome .	
2	Hygier Hygier Ther ti		11 th 17. Father's Name (First, Middle, La	et)		HOIII	emaker	18 Mothe	r's Name	(First, Middle	1		
Maryland 21215-0036	d be f	o Be	Cyrus Clement							Renne		,	
Z Z	shoul nd Mo mari	은	19a. Informant's Name/Relationship	_	aw	19b. Mailir	g Address (Street					Town, State,	Zip Code)
	alth a		Judith E. Geary	/ Daughter	r-In-	19009	Rock Maple	Drive,	, Hage	rstown,	MD 21	742	
ore,	of He		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	□ Removal from State	1 0	Place of Dispo	sition (Name of matory or other place	ce)		ate			r Town, State
altimore,	Pag ment ant: I		4 ☐ Donation 5 ☐ Other (Spe	ocify)	Res		Cemetery		05/19/			stown, 1	
Ball	permit Depart Import eny in		21. Signature of Funeral Service Lic	ensee	_		Name and Addre						uneral Home MD 21740
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	omplications that cause by one cause on each	d the deat	th. Do not ent	er the mode of dyir	ng, such as	cardiac or	respiratory a	ırrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	agane	aren	e RI	- fool-						3weike
	/Medical Examiner		resulting in death)	Due to (or as	sa conseq	(uence of):	-1						
	Lxammer	_	Sequentially list conditions,	b. Due to (or as	E B CYCERO	usomina (18):							
Т	ted nsit	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 00	. a conceq	100.100 017.							
ć	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as	s a conseq	(uence of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcal		d.									
9	ing ph	0	IF FEMALE:										
Вох	that the death certificed by the attending properties as	by Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	aldeath 3□	Ectopic pregnancy	/			2	3d. Date of d Month	elivery Day Year
о О	he de the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of d	ieath 5	Other (specify) _						
P.O.	res that t igned by be detac	F.	Part II. Other significant conditions	s contributing to death	but not res	sulting in the u	nderlying cause giv	en in Part I.		23e. Did	tobacco u	se contribute	to the cause of death?
rds	quires n sign ald be	Q D								1 🗆	Yes 2	□No 3 □	Probably Unknown
Division of Vital Records,	aw require s been si 2 should b	Completed								24a. Was		24b. Were	autopsy findings available o completion of cause of
<u> </u>	The lav	mo									ormed?	death	?
ita	i ician : Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	H				26. Place	of Death	(Check only			
<u>></u>	Physician: rthis certific ral director.	ပ္	1 ☐ Yes 2 ☑ No	Hospital:		ER/Outpatier		NU	_			Other (S)	oecify)
Ž	ting P	lon	27. Magner of Death 1 Selection 1 Selecti	28a. Date of Inj (Month, Da	ay Year)	28b. Time o Injury	Wor	ryat rk? Yes 2 □		8d. Describe	now injury	y occurred	
isi	if or Attending after death. Director: After d in by the fune	licat	2 Accident investiga 3 Suicide 6 Could no	t be 290 Blace of In	niury - At h	ome, farm, sti	reet, factory, office	163 2		8f. Location	(Street and	d Number or	Rural Route Number,
<u>S</u>	after after Dire	Certification;	4 Homicide	building, e	etc. (Specii	<i>fy</i>)	,,			City or To	wn, State,)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical C		Physician: To the besi xaminer: On the basis and manner s	of examina								
_	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	se number			29d. Dat	e signed (Mo	nth, Day, Year)
	> 0		1 Marier	i gonces	4		020	8365	-		5	-16-1	<u>L</u>
_	., .1		30. Name and address of person wi	no completed cause of	death (Iter	m 23a) (Type,	Print)			,			
7	W-4		MANZAR.). SHAP.	36	0	wie str	el-1	terg	25/200	17	02179	0
	Sta Regist	ate rar	31. Date filed (Month, Day, Year),	2012 32. regis	trar's Signa	ature	and a						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mavonth11. 7:25 2012 A M Gonzalez **Gladys** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Fort Washington Medical Center Fort Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9 Birthplace (State or Foreign **Funeral** Davs Hours July 12, Year) 1932 79 Director 337-48-7882 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2X No Miami-Dade Miami Florida 10e. Street and Number 10f. Zip Code ms 23a or must be n ö 10g. Citizen of What Country? Funeral U.S.A. 33145 2501 SW 21 Street r than "natural", or items the Medical Examiner mus Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: Cuban If Yes, Give Year or Dates White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Angela Perdomo Bernardino Alvarez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8940 SW 4 Terr. Miami, FL 33174 Nitza Gonzalez (Daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☑ Burial 2 ☑ Cremation 3 ☑ RemovaLfrom State Woodlawn Park Crematory 5/25/2012 Miami, FL Donation 5 ☐ Other (Specify) nature of Fun ral Service Licen 22 Name and Address of Faculty Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ as disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immodute cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abused and use as the burial-transi Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Natural 28b. Time of 28c. Injury at 5 \square Pending work 1 Yes 2 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year 00063171 11/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FORT WASHINGTON MD 20744

State Registrar

DHMH 17 Rev 7/2009

KAREN

31. Date filed (Month, Day, Year)

RD

11711 LIVINGSTON

32. Registrar's Signature

MD

DIXBN

MAY 14 2012

12-03592 Rafet Gerigiden Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

aret Gerigiden	1-For State Certifica Registrar	te of Death	Reg. No	2012 1698
Physician/	Decedent's Name (First, Middle,Last)		Date of Death Month Day	3. Time of Death Year 0155 hrs
Medical Examiner	Rafet 4a. Facility Name (if not institution, give street and number)	Gerigiden 4b. City, Town, or Location of Dea	May 10, 2012 ath 4	c. County of Death
	Route 10 SB at Furnace Branch Road	Glen Burnie		Anne Arundel
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birth		lin	I/DD/YYYY) 9. Birthplace (State or Foreign
Director	075-80-2653 1 M 2 F 42	Yrs.	Jan. 13,	1970 Country/Turkey
any	10a. State 10b. County 10c. City, Town o	r Location	-	10d. Inside City Limits
Maryland 28a-f show d at once. rector	Maryland Anne Arundel Glen Bu			1 X Yes 2 No
the Maryland a or 28a-f sh tified at once Director	10e. Street and Number 3 Marley Neck Road	10f. Zip Code 21060		tizen of What Country? urkey
- 6 5	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian, Black,
or death with	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	White, etc.
ura", miner	3 Widowed 4 Divorced of the Solve Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. D	1 Yes 2 No specify: ecedent's Usual Occupation (Give kind	of work done 16b.	Specify: White Kind of Business/Industry
5-0036 led within 72 hours after Hygiene, a satural", to ther than "natural", the Medical Examinet Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT use r		
oo3(within piene. Media	12 Cab	le Contractor	me (First, Middle, Maider	orcan, LLC
21215-0036 suld be filed within 7 Mental Hygiest event, the Medical FO BE Comple	Mehmet Gerigiden	Fatma		, oanamo,
2121() bould be fill and Mental F. is marked itic event, I		Mailing Address (Street and Number of		
and 2 sho ealth and 2 cm 27 is traumati		Marley Neck Rd., O		, MD 21060 Location - City or Town, State
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is n injury or other traumatic	Safran	y or other place) abolu Cemetery 5/	16/2012 Ka	arabuk, Turkey
altin mit. P partme portar ury or	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22 Name and Address of Facility Metropolitan Fune 5517 Vine St., Al		-
	23a. Part I. Enter the disease, or complications that caused the death. Do not	5517 Vine St., Al	exandria, V	7A 22310
Physician /Medical	failure. List only one cause on each line.	onto the three of dying, business sende	o or roophatory unroot, on	Between Onset and Death
Examiner	or condition resulting in death) a. Multiple Bluft Force injuries Due to (or as a consequence of):			
9	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
a min	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
60, ate be exemted hysician an e burial - transit Medical Examiner	d.			
60, ate be exe hysician a e burial -	UNPENDED AMENDED			
876 ufficate ing phy as the lan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2	Fetal death 3 Ectopic preg		3d. Date of delivery Month Day Year
b. Box 687, the death certification by the attending probe of for use as the Physician/I	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
. 8 18 5	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
s, P.O. ires that the signed by de detacl by E detacl by E detacl by E detacl by E detacl by E detacl by E detacl by E detacl by E detacl by E detacl by E			-	✓ No 3 Probably 4 Unknown
of Vital Records, Is grhysician: The law requires the this certificate has been signeral director, page 2 should be n: To Be Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
tal Rection: The lectrificate lector, page		20 Blood of Booth (Cha	1 ✓ Yes 2 1	No 1 Yes 2 No
Vital I ysician: ysician: his certifi director,	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out	26.Place of Death (Che		lence 6 🗸 Other: Scene
on of Vital ending Physician: erath. the funeral director, trion: To Be (27. Manner of Death 28a. Date of Injury 28b. T.	me of Injury 28c. Injury at Work?	28d. Describe how in Driver auto fixed	
Division tal or Attendi rs after death. al Director: /	2 Accident Investigation May 10, 2012 0143	11 163 2		and Number or Rural Route Number, City
Division o Biopital or Attending 24 hours after death. Funeral Director: Afteredy filled in by the funeral Control or and Contification:	3 Suicide 6 Could not be determined (Specify) Major Road / Hig			ace Branch Road, Glen Burnie, MD
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat			
To the Ho within 24 I To the Fu completely	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier	29c. License number		. Date signed (Month, Day, Year)
10	W2	OCME		y 10, 2012
	30. Name and address of person who completed cause of death (Item 23a)			
		900 W. Baltimore Street, Balti	imore, MD 21223	
State Registrar	31. Date filed (Month, Day, Year) NAY 1 4 2012	parle		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 A^{M} GARCIA APR 2:05 Medical KEVIN 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY WALTER REED NATIONAL MEDICAL CENTER BETHESDA Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 1/ 9. Birthplace (State or Foreign **Funeral** Days Mir 066-64-9020 43 New York **Director** 1969 Usual Residence of Decedent show 10a. State 10b. County or 28a-f sho notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1X Yes 2 □ No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 1200 East West Highway 20910 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 \(\text{\text{No}} \) No 2002-Black, White, etc ģ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 XI Yes 2 □ No Specify: Puerto Rican If Yes, Give Year or Dates White Specify: 3 - Widowed 4 - Divorced 2012 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Army permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other any injury or other traumatic event, the once. Soldier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Raymond Garcia-Gonzalez Maria Socorro Fragosa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Garcia/Wife 1200 East West Highway Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State National Crematory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/16/12 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA 21. Signature of Fun Servi 22. Name and Address of Facility Murphy FH 4510 Wilson Blvd. Arl., VA 22203 Une 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ METASTATIC RENAL CELL CARCINOMA disease or condition a. Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ atter in the past 12 months?
1 Yes 2 No jo Pregnant at time of death Month Day signed by the a Hospital or Attending Physician: The law requires that the or 24 hours after death.
Funeral Director: After this certificate has been signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? Yes 2 XNo 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ည 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred ☐XNatural ☐ Accider 5 \square Pending М 1 Tes 2 🗌 No Accident Investigation the 3 Suicide 4 Homicide 6 Could not be To the Hospital or Atter within 24 hours after der To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier PUMERANTZ, DO 29c. License number



State Registrar AARON W.

31. Date filed (Month, Day, Year)

1 4 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DO

PUMERANTZ,

VA 0102202848

5 2012

MD

WALTER REED NATIONAL MEDICAL CENTER

20889

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9 State of Maryland Department of Health and Mental Hygiene 12-03811 Jon Christopher Gauss, Jr. 2012 | 6991 1- For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Day May 18, 2012 1720 hrs Medical Examiner Christopher Gauss, Jr. Jon 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rt. 64 & Rt. 491 Smithsburg Washington 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birtholace (State of o, PA Funeral Months Days Hours Director 213-25-8108 May 28, 1989 Country) 1X M 2 F 22 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Cascade 1 Yes 2 No 23a or 28a-f show notified at once. MD Washington death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21719 US 24830 Pen Mar Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' White, etc. 1 X Never Married 2 Married Yes 2 X No Pages I and 2 should be filed within 72 hours after onen of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", o 4 Divorced If Yes, Give Yeer or Dates: 3 Widowed 1 Yes 2 No specify: Specify: white 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 car dealership automotive technician 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jon Christopher Gauss, Sr. partment of Health and Mental F portant: If item 27 is marked ury or other traumatic event, i Be Kathy E. Buhrman ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B Cascade, MD 21719 24830 Pen Mar Rd. John Christopher Gauss, Sr. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, May 21, ore. 1 Bun'al 2 Cremation 3 Removal from State crematory or other place) Waynesboro, PA 17268 Cumberland Valley Crem. 4 Donation 5 Other Specify permit. 22. Name and Address of Facility 21. Signature of Puneral Service Licens Grove-Bowersox Funeral Home, Broad St. Waynesboro, PA S. 23a, Part I Enter the sease, or cor inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical UNPENDED AMENDED attending physician or use as the burial The law requires that the death certificate be Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown for Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. ڎ 1 Yes 2 No 3 Probably 4 Unknown Completed ficate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical director, Be examiner? Other Nursing Home 5 Residence 6 🗹 Other: Scene Inpatient 2 ER/Outpatient 3 DOA this ٥ 1 Yes funeral After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: May 18, 2012 Driver auto auto collision 1711 hrs Division Natural 5 Pending 1 Yes 2 No death. hours after death. the 2 🗹 Accident Investigation by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) Rt. 64 & Rt. 491 , Smithsburg, MD within 24 hours a

To the Funeral I determined (Specify) Local Street Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month Day Year) 58m O.C.M.E. May 19, 2012 30. Name and address of person who completed cause of death (Item 23a) COME Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:59 A Physician/ 9,2012 Thelma D.Hare Mary Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1194 Hammond Lane 0denton Anne Arundel Social Security Number **Funeral** If Under 1 Year Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 217-36-3192 **Director** 1 M 2 F 74 04/28/1938 Baltimore, MD 28a-f show 10a. State with the Manyland 10b. County Director 10c. City, Town or Location 10d. Inside City Limits must be notified at MD Anne Arundel Odenton 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1194 Hammond Lane 21113 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No 3 ₩ Widowed 4 □ Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Administrator Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Dicus Ursula Diechgraber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Hare Jr. 1359 Rosanna Drive Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Church of God 05/12/2012 Gambrills, MD 21. Signature of Funeral Service 22. Name and Address of Facility 851 Annapolis Road Gambrills, MD 21054 Hardesty Funeral Home P.A. 23a. Part 1. Ent in edisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Due to (ras a consequence of) **Examiner** Sequentially list conditions, Examiner Due to the as a consumulation of cause. Enter Underlying Cause (Disease or injury that initiated events physician are s the burial-t Due to (or as a consequence of) Be Completed by Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 attending IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ Live Birth 2 Fetal death Pregnant at time of death for in the past 12 months?
1 Yes 2 No Month Day 9 🔲 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has lirector, page 2 autopsy death? perform 25. Was case referred to medical 26. Place of Death (Check only one) ျှ 1 Tyes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify this 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? ☐ Accident Investigation 2 No 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 28f. Location (Street and Number or Rural Route Number. City or Town, State

Division of Vital Records, P.O. s after death. To the Hospital within 24 hours a To the Funeral D

> State Registrar

Medical

29a. Certifier only one

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) MAY 11 2012

305 Hospital Drive Russell DeLuca M.D.

Certifying Nurse Practitioner: To the bast of my knowledge death

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nume, Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Glen Burnie, MD 21061

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 5 **Physician** 10:58P ^M Florence M. Hall May 2012 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hammonds Lane Nursing Center Brooklyn Park Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 18 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🔀 F 215-64-4370 1953 Maryland Director Usual Residence of Decedent r 28a-f show notified at 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be 6435 Grafton Garth Ct. 21061 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □ Yes 2**X** No Specify: Specify: Black δ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th \cap Homemaker None marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked othany in jury or other traumatic event Be Raymond Watkins Margaret Parker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samantha Elliott(Daughter) 6435 Grafton Garth Ct. Glen Burnie, Md.21061 Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of certainty strengther place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Gardens 5-11-12 Annapolis, Md. 4 Donation 5 Dother (Specify) WinName Receive of SeciliSons Mortuary, 21. Signature of Funeral Service Licensee 1922 Forest Dr. Annapolis, Md. 21401 Larry Gilles 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** unoton disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Dav in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknow signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performe 2 No Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendl within 24 hours after death. To the Funeral Director A death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

DHMH 17 Rev 1/2001

State Registrar Jude

29b. Signature and title of certifier

ss of person who completed cause of death (Item 23a) (Type, Print)

indswept ct. Baltimore MD 21047

30. Name and add

29c. License number

D53465

29d. Date signed (Month, Day, Year)

१०/१२

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 2012 Paul David HULL Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) Director 220-34-0085 1 X M 2 □ F 81 Oct. 24 1930 Maryland Usual Residence of Decedent 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl notified 1 Nes 2X No Maryland Washington Hagerstown ō 10e. Street and Number ms 23a or must be n 10g. Citizen of What Country? Funeral 11403 Stonecroft Court 21742 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: "natural", Year or Dates. U.S. Army Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. s marked other than " umatic event, the Mec Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Mfg. Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ of Health and Menta item 27 is marked other traumatic e Samuel T. Hull Martha M. Gladhill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31702 Green Forrest Dr. Little Orleans, Md. 21766 <u> Helene Keefer - Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 5/18/12 Hagerstown Crematory Hagerstown, Maryland Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home 1740 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Day 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cmys Lyona, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No ☐ Yes 2 No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) 1 ☐ Yes No Hospital Other မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death
Natural
Accident Certificate: 28a. Date of injury 28b. Time of 28c. Injury at I or Attending P safter death. Director: After t 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation ☐ Æccider
☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Hospital 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signa 0063 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21742

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05 Physician/ Hammersla 1230p M May 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Julia Manor Healthcare Havenestown Washington If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Director 218-24-2337 1 □ M 2 🔀 F 82 May 8 1930 West Virginia show 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Yes 2 No Maryland | Washington Williamsport 10e. Street and Number 10g. Citizen of What Country? by Funeral 339 S. Artizan Street 21795 USA death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 X No 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) 12 Health Care Retarded Citizens 0 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Zella (Unknown) Walter Dean 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 Artizan Street, Williamsport, Md. 21795 Charles Hammersla - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State 0 Department Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 5/18/2012 Williamsport, Md. Greenlawn Mem. Park 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licenses KE Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final a NON-Small Cell Onysician/ iarcinoma of the Lung disease or condition resulting in death) 8 months Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). ardiomyo path burial-tran that initiated events resulting in death) Last signed by the attending physician d be detached for use as the buria Be Completed by Physician/Medical orodary astery Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus, HypothyRoidism, Vascular Division of Vital Records, icate has been sig r, page 2 should b 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Dementia with Depression, Anxiety Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 24 hours after death.

Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: မ 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at Medical Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 □ Yes 2 □ No Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Naden-Blucker, CRNP-333 Mill Street, Hagerstown, MD 21740 State

Registrar
DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra MEND#26&29apenMD,5/24/12; BMN,Moto Certificate of Death 2. Date of Death 3. Time of Death Physician/ Month 5 Year Harris cause PM 7:04 Medical 2017 **Examiner** 4a. Facility Name (if not institution, 4b. City, Town, or Location of Death 4c. County of Death University of wayland Baltimore 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 216-64-2893 3/19/1952 Wash., D.C. Director 60 1 M 2 X F 28a-f show 0a. State items 23a or 28a-f sho her must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Wheaton 1 🗆 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2810 Lindell Street 20902 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ite þ 1 Never Married 2 X Married ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home and Mental Hygier is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman S.Clifton Adeline Cribella permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Harris/Husband 2810 Lindell Street Wheaton, Md. 20902 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Reg 4 Donation 5 Other (Specify) Chesapeake Crem. 5/15/2012 Beltsville, Md 21. Signature PHTETP TO RETAIL FUNERAL SERVICE, P. A. 9241 Columbia Blvd. Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart allure. List only one cause on each line Interval Between Pueurosia Immediate Cause (Final Onset and Death Friysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year signed by the a d be detached f the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed? Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Hospital: Other: 1 Tes ျာ 1 X Inpatient 2 🗆 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this opmpletely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature ap 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

Tes: devt Physicsau s of person who completed cause of death (Item 23a) (Type, Print) ZACHARY DEZMAN 22 S. Green

62. Registrar's Signature

AU4176435Z101597

22 S. Greene St. Bultimore, MD 2120

11/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep			iental Hyg	iene	2 10	007		
		_1	negistrar	ertificate of Dea	ath .	R	eg. No. ZUI	2 10	991		
	Physicia		1. Decedent's Name (First, Middle, Last)			2. Date of Deat Month	Day Yea	3. Time of			
	Medic	al .	Ann D. Hammer ta. Facility Name (if not institution, give street and number)			May 9,	1	4:00			
	Examin	er	Renaissance Gardens at Riderwood Vill	4b. City, Town, or Loca	Spring		4c. County of Di	eatn			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If L	Under 24 Hrs.	8. Date of Birth	9.	Birthplace (State o	r Foreign		
	Director		138-03-8283 1 □ M 2 🖾 F 98 Yrs.	Months Days Ho	ours Min.	(Month, Day,		Country) PA			
	d t	_	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or 1	ocation		idi cii 1,	171	10d. Inside Ci	ity Limits		
	arylan a-fsk fied a	Director		er Spring				1 🗌 Yes	2 🛣 No		
	the Mi or 28 e noti		10e. Street and Number	10f. Zip Code			10g. Citizen of What	Country?			
	with	Funeral	3112 Gracefield Road, PV 318	20904			USA				
9800	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Health and Mental Hygiene. The marked other than "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	8. Was Decedent of Hispan If Yes, specify Cuban, Mi 1 ☐ Yes 2 🎦 No Sp		cify Yes or No- Rican, etc.)	14. Race - A Black, W Specify. Wh	merican Indian, hite, etc. ite			
Baltimore, Maryland 21215-0036	in 72 hou e. nan "nat Medica	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during DO NOT use retired)		ng	16b. Kind of Busine	ŕ			
21	d with lygien ther th	ادہ ا		retary		<i>(</i> (1) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Govern	nent			
and	ntal H red of ced of	To B	17. Father's Name (First, Middle, Last) Ernest DiCanzio			Finare	Maiden Surname)				
Ę.	ould bud Me Ind Me Imark Imatic	Ė		illing Address (Street and I				Zip Code)			
M	d 2 sh alth ar 27 is rrtrau	1		South Wayne			-		204		
ore,	of Her of Her fitem		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition	position (Name of rematory or other place)	С	oate unk	20c. Location - City	or Town, State			
Ë	Page ment ant: I	1	4 Li Donation 5 Li Other (Specify)	on National Cemetery			Arlington	ı, VA			
Balt	permit. Page 1 a Department of I Important: If ite any injury or of once.	-	James & Jacole	Francis ^{Adgess} (500 Universi	ity Blvo	1. W., S	ilver Spr		20901		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, su	uch as cardiac o	r respiratory arre	est,	Approximat Interval Bet Onset and	tween		
	hyvicien/		Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic	Cardiovascu	ılar Dis	sease		1 yr	Deam		
1	Medical Examiner		Due to (or as a consequence of):					1			
6		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence oi).					2			
	Parisit d	Examine	cause, Enter Underlying Cause (Disease or injury that initiated events								
	te be executed any sician and the burial-transit		resulting in death) Last Due to (or as a consequence of):								
09	ate be hysici the bu	dica	d								
68760	that the death certificate be executed ned by the attending physician and a detached for use as the burial-trans	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy				22d Data of	dolivon			
Вох	ath ce attend for us	cian	23b. was decedent pregnant 1 Live Birth 2 Fetal death	B			23d. Date of Month	-	Year		
B.	the de sy the ached	hysi	9 Unknown								
	requires that the been signed by should be det		Part II. Other significant conditions contributing to death but not resulting in the Anemia	e underlying cause given i	in Part I.		bacco use contribut 'es 2 😾 No 3 □				
of Vital Records,	The law requires ate has been sign page 2 should be	Completed by				24a. Was a		autopsy findings			
eco	sician: The law r certificate has b lirector, page 2 s	ldu			-	autop: perfor	sy prior med? deat	to completion of a h?	cause of		
B		Be Co	25. Was case referred to medical	26. Place	of Death (Check	1 Yes	2 X No 1 1 L	Yes 2 No			
Vita	Physician: this certific ral director,	To B	examiner? 1 Yes 2 XNo Hospital: 1 Inpatient 2 ER/Outpa	tient 3 DCA Other:	4X Nursing Ho	me 5 Resid	ence 6 🗆 Other (S	pecify)			
	ter The		27. Manner of Death 1 → Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) 28b. Time injur	y work?	1	28d. Describe ho	ow injury occurred				
ion	Attending or death. ector: After by the fune	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		2 🗆 No	28f Location /S	treet and Number or	Rural Route Num	ber		
Division	tal or A		4 Homicide determined building, etc. (Specify)			City or Town	n, State)	Trada Trada			
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
ō	# Nithing		29b. Signature and title of certifier	29c. License nur	mber 633		29d. Date signed (M	pnth, Day, Year)			
			30. Name and address of person who completed cause of death (Lern 23a) (Type Julaine Harding, CRNP 3160 Grace								
	Sta Registr		31. Date filed (Month, Day, Year) 2012 2. Registrar's Signature	wed.							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12, 3. Time of Death Physician/ 2012 2:00 ΡМ May Walter Lewis Holsinger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster The Woods of Sun Valley 8. Date of Birth
(Month, Day, Year
April 26, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 5ex 1 **X** M 2 □ F Days Hours Months 95 Virginia Director 229-01-9985 Usual Residence of Decedent show should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 ☐ Yes 2 🄀 No Eldersburg Maryland | Carroll 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral United States 21784 114 Henry Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes Give Specify: Caucasian Completed 3 X Widowed 4 □ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Coca Cola -8-Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hi Important: If item 27 is marked ott any injury or other traumatic even John L. Holsinger Anna Mary Yates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 114 Henry Avenue Eldersburg, Maryland 21784 Gretchen L. Jones - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Mt. Comfort Cemetery | May 16, 2012 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses

22. Name and Address of Facility Jefferson
5755 Castlewellan Drive Ale

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Jefferson Funeral Chapel 5755 Castlewellan Drive Alexandria, Virginia 2231 shock, or heart failure. List only one cause on each line. Immediate Cause (Final tean onvestive Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): g physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) Pregnant at time of death Yes 2 No s been signed by the should be detached Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Completed by Mellitas 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ementis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner: Asst lining Hospital: 2 × No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Tother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No injury 1 Natural 5 Pending nours after death, neral Director: Aft d filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital of within 24 hours a To the Funeral D completed filled i Medical 🗄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) westminsk MD 21157 MAHMOUD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2012		6	9	9	9
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Dearlore Hollio	ay	1- For State	Maryland / Dep	ertificate of		i Mental H	_	2	012 1699
Physic	ian/	1. Decedent's Name (First, Middle,Last)					2. Date of Dea		3. Time of Death
Medical Exam	nine	podiate noite					Month May 13, 2	Day Yea 2012	1819 hrs
*		4a. Facility Name (if not institution, give steepers of the Prince George's Hospital Ceres.)		4	b. City, Town, or L Cheverly	ocation of Death)	4c. County o	
Funera		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24Hrs	. 8. Date of Bi		9. Birthplace (State or
Directo		577-82-2114 1XM	2 F 43	Yrs.	Months Days	Hours Min		/1969	Foreign Country) DC
	1	Usual Residence of Decedent					102/00	71909	" DC
ow any		10a. State 10b. County	10c. City	y, Town or Location	on				10d. Inside City Limits
Maryland 28a-f show d at once.	ફ	DC 10e. Street and Number		Washingt	On 10f. Zip Code			10g. Citizen of Wh	1 X Yes 2 No
the Ma	Director	3908 Kansas Ave. N	T.J		·				at Country?
hours after death with the Maryland "natural", or items 23a or 28a-f sho Examiner must be notified at once.	Pra	11. Marital Status 12	Was Decedent Ever in U	J.S. 13. Was	20011 Decedent of Hisp	anic Origin? (Sp	ecify Yes or No		- American Indian, Black,
r death or ite	Funeral		Armed Forces? Yes 2 X No		s, specify Cuban,		Rican, etc.)	White	etc.
rs afte ural", miner	<u>ج</u>	3 Widowed 4 Divorced of 4 15. Decedent's Education (Specify only h	latee.		Yes 2 X No s Usual Occupatio		and dis-		Black
72 hou	Completed		College (1-4 or 5+)	during mo	st of working life. [OO NOT use reti	red)	16b. Kind of Bus	iness/industry
OO36 within 72 giene.	ם	12		Invest	or			Real Es	tate
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	ြင္မ	17. Father's Name (First, Middle, Last)			18			Maiden Surname)	
212 uld be Menta mark	To Be	Frank Holliday, Jr 19a. Informant's Name/Relationship (Type.		19b. Mailing	Address (Street :	Queen	A. Gre	en nber, City or Town	State 7in Code)
MD 21215-0036 ad 2 should be filed within 72 lith and Mental Hygiene. n 27 is marked other than " numatic event, the Medical ?	-	Queen A. Holliday/M	other					gton, DC	
		20a. Method of Disposition 1 XBurial 2 Cremation 3 F	20b.	Place of Disposit crematory or other	ion (Name of ceme	etery,	Date		City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ites injury or other tr		4 Donation 5 Other Specify:	Han			ark 05/1	19/2012	Landove	r, MD
Balt Permit. Depart Impor		21 Signature of Funeral Service Licensee		22. Na	me and Address o	fFacility Man	shall-	March Fu	r, MD neral Home
Physician		26a. Par I. Enter the disease, or complicati	more 7	. Do not enter the	1/ 9th St	treet NV	V, Wash:	ington, l	DC 20011 t Approximate Interval
/Medical Examiner		failure. List only one cause on each li	_{le.} ite Myocardi				, , , , , , , , , , , , , , , , , , , ,		Between Onset and Death
Examiner		or condition resulting in death) Due	o (or as a consequence o	of):		4.6	1	D:	
	ler	if any, leading to immediate Due	o (or as a consequence of		Lerotic C	ardiova	scular	Disease	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated							
ecuted and transit		events resulting in death) Last Due d.	o (or as a consequence o	or):					
ex ian	Physician/Medical	X UNPENDED X AN	ENDED23a,23e,	pt.II,2	,per me,	g928 6-	1-12 sn	1	
760, ficate be g physic sthe bur	/Me		c. If yes, outcome of preg			l		23d. Date of d	
x 6876 th certificat tending ph	iciai	past 12 months?	Live birth Pregnant at time of de	ath	Ideath 3 ∟ er (Specify)	Ectopic pregnar	icy	Month	Day Year
Box he death c	hys	1 Yes 2 No 9 Unknown 9	Unknown						
rres that to signed by be detac	ē	Part II. Other significant conditions cont Cocaine and Oxycod		esulting in the un	derlying cause give	en in Part I.			Probably 4 Unknown
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Vital Records, hysician: The law require this certificate has been siderector, page 2 should be	dmo						autop:	med? dea	or to completion of cause of ath?
tal Recian: The certificate	Be Co	25. Was case referred to medical			26.Place of	Death (Check or	1 Yes 2	2 No 1	Yes 2 No
Vita hysici this o	10 B	examiner? 1 ✓ Yes 2 No	al: 1 Inpatient 2 🗹	ER/Outpatient		her 🗔		Residence 6	Other:
n of ding Pl n. After funeral		27. Manner of Death 1 Natural 5 Pending	8a. Date of Injury (Month, Day,Year)	28b. Time of Inju			28d. Describe h	ow injury occurred	
Division tal or Attendi rs after death. al Director: /	icati	2 Accident Investigation	8e. Place of Injury - At ho	ome farm street		2 No	Of Leasting (O	Anna and Name	
Div ital or urs afte	Certification:	Suicide Could libt be	(Specify)	onio, idini, onoci,	ractory, office ball	ang, etc.	or Town, St		or Rural Route Number, City
Division of To the Hospital or Attending Pl within 24 hours after death. To the Fuoeral Director: After completely filled in by the funeral		29a. Certifier 1 Certifying Physician: T	the best of my knowledg	ge, death occurre	d at the time, date	and place, and o	lue to the cause	e(s) and manner a	s stated.
To th withir To th compl	Medical		ne basis of examination ar manner stated.	nd/or investigation			the time, date a		
m		29b. Signature and title of certifier			29c. License n			29d. Date signed May 15, 201;	(Month, Day, Year)
(4)	}	30. Name and address of person who compl	eted cause of death (Item	23a)				191ay 13, 201	
		Ana Rubio MD. Assistant Me	edical Examiner 9		ore Street, Ba	ltimore, MD	21223		
St Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re arkel					
Negis	ш	MAT I O CUIZ Kellige	10. All	Mercan					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death $\mathbf{M}\mathbf{A}\mathbf{Y}^{\mathsf{Month}}$ ^D2012 Physician/ HARRY DAVID HOLDING а м 4:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Elkton Laurelwood Care Center 7. Age (In yrs. last birthday) 78 Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** Days Hours 219-28-1775 1 🔀 M 2 🗆 F Jan 28 Marvland f934 Director Usual Residence of Decedent 10b. County and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Ħ 10a State Director Examiner must be notified 1 Yes 2 X No Earleville MD Cecil 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral 21919 U.S.A. 2658 Crystal Beach Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 21215-0036 White 1 ☐ Yes 2X No Specify: Completed 3 XWidowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Road Laborer Cecil County Roads Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Catherine Parker George Holding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28878 Moranec Rd. Kennedyville, MD. 21645 David M. Holding (son) injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 X Burial 2 Cremation 3 Removal from State 5/24/12 Galena, MD. Galena Cemetery 4 Dopation 5 Other (Specify) 22. Name and Address of Facility
Galena Funeral Home of Stephen L. M00510 118 West Cross St. Galena, MD. 21635 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art failure. List only one cause on each line. Part 1. Enter shock, or hea Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PROSTATE CAPLINONA disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mopleted filled in by the funeral director, page 2 should be detached for use as the burial-transit mopleted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ER/Outpatient 3 DOA ဂ္ 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within 7 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number P. V. Naye DOO 65733 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EAST 416H STREET ELKTON RA 14 A. NARAYANA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 0 2012 Registrar

DHMH 17 Rev 7/2009